Arizona Health Care
Cost Containment System (AHCCCS)

AHCCCS

2006–2007 External Quality Review Annual Report *for* Acute Care and DES/CMDP Contractors

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA) added Section 1932 to the Social Security Act (the Act), which pertains to Medicaid managed care. Section 1932(c) of the Act requires state Medicaid agencies to provide for an annual external independent review of the quality and timeliness of, and access to, services covered under each managed care organization (MCO) and prepaid inpatient health plan (PIHP) contract. The Code of Federal Regulations (CFR) outlines BBA requirements related to external quality review (EQR) activities.

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, §438.358(b) and (c). The three mandatory activities are: (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), "The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities."

AHCCCS was the first statewide Medicaid managed care system in the nation. It is recognized as a leader in designing and administering effective service delivery models for Medicaid managed care programs. Based on its extensive experience and expertise in managing and overseeing its Medicaid managed care programs, AHCCCS elected to conduct the mandatory activities. The agency developed and has consistently followed valid, tested models and processes to:

- Prepare for conducting each of the activities.
- Determine MCO and PIHP (i.e., "Contractor" within the AHCCCS system) compliance with financial and operational performance standards.
- Collect Contractor encounter and other data and use the data to directly calculate and measure Contractor performance for the AHCCCS-selected performance measures and required PIPs.
- Conduct overall validation of encounter data according to industry standards.

To meet the requirement of 42 CFR §438.358(b), an external quality review organization (EQRO) must use information from the three mandatory activities for each MCO and PIHP to prepare an annual technical report that includes the EQRO's:

- Analysis of the information.
- Conclusions drawn from the analysis of the quality and timeliness of, and access to, Medicaid managed care services provided to members by the State's MCOs and PIHPs.
- Recommendations for improving service quality, timeliness, and access.

AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG), to analyze the information AHCCCS obtained from conducting the mandatory activities and to prepare this 2006–2007 annual report. This is the fourth year that HSAG has prepared the annual report for AHCCCS. The report complies with requirements set forth at 42 CFR 438.364.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or that the state derived from conducting the activities. HSAG uses the information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the state's MCOs and PIHPs provide.

This Executive Summary section includes an overview of HSAG's 2006–2007 external quality review and a high-level summary of the results. The results include a description of HSAG's findings with respect to AHCCCS Contractor performance in complying with federal and State standards, improving performance on AHCCCS-selected measures, and conducting valid and effective AHCCCS-required PIPs. A summary of HSAG's overall findings, conclusions, and recommendations across the three performance areas is also included in this section.

Additional sections of this 2006–2007 annual report include the following:

- Section 2—An overview of the history of the AHCCCS program and a summary of AHCCCS's quality assessment and performance improvement (QAPI) strategy goals and objectives
- Section 3—A description of the 2006–2007 EQRO activities that HSAG conducted
- Section 4—An overview of AHCCCS's statewide quality initiatives across its Medicaid managed care programs and those that are specific to the Acute Care program (i.e., Acute Care Contractors and the Arizona Department of Economic Security/Comprehensive Medical and Dental Plan [DES/CMDP] Contractor
- Section 5—An overview of the Contractors' best and emerging practices
- Section 6 (Organizational Assessment and Structure Performance), Section 7 (Performance Measure Performance), and Section 8 (Performance Improvement Project Performance)— A detailed description of each of the three mandatory activities that includes for each activity:
  - AHCCCS's objectives for conducting the required activity and HSAG's objectives for aggregating and analyzing the data and preparing this report of findings and recommendations.
  - AHCCCS's methodologies for conducting the activity and HSAG's methodologies for using the AHCCCS data to prepare this annual report, including the technical methods of data collection and analysis, description of the data obtained, and how conclusions were drawn from the data.
  - Contractor-specific results and statewide comparative results across Contractors, including an assessment of Contractor strengths and opportunities for improvement.
  - HSAG's recommendations for improving the quality and timeliness of, and access to, care and services Contractors provide to members.

Overview of the 2006–2007 External Review

During contract year (CY) 2006–2007, AHCCCS contracted with nine Contractors to provide services to members enrolled in the AHCCCS Acute Care Medicaid managed care program. The nine Contractors were: Arizona Physicians IPA, Inc.; Care1st Health Plan Arizona, Inc.; Health Choice Arizona; Maricopa Health Plan; Mercy Care Plan; Phoenix Health Plan, LLC; Pima Health

System; University Family Care; and the Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP). As described previously, AHCCCS directly performed the following functions related to the three mandatory activities for CY 2006–2007 for the Acute Care and DES/CMDP Contractors:

- Conducted an extensive operational and financial review (OFR) of Contractor performance in meeting standards established by AHCCCS to comply with federal and State regulations, rules, and contract requirements. AHCCCS categorized and organized associated standards within 13 performance areas.
- Collected Contractor encounter and other data and used the data to directly calculate, analyze, and report Contractor performance for the AHCCCS-selected performance measures.
- Collected Contractor encounter and other data and used the data to directly calculate, measure, and report Contractor performance for the AHCCCS-required PIPs.
- Conducted overall validation of Contractor encounter data according to industry standards.
- Compiled and provided to HSAG: (1) A comprehensive and detailed written description of the processes and methodologies it followed in conducting the three mandatory activities related to Contractor compliance with standards, performance measures, and PIPs; and (2) Contractor-specific performance results AHCCCS obtained from conducting each of the activities.

On January 16, 2008, HSAG and AHCCCS met to discuss and clarify AHCCCS's expectations for the annual external quality review report of findings for the three mandatory activities that AHCCCS performed. AHCCCS provided to HSAG detailed written information about the processes AHCCCS followed in conducting the activities and the Contractors' performance results for each. HSAG reviewed AHCCCS's documentation and developed a summary tool to crosswalk the data related to the Contractors' performance for each of the activities. Following a preliminary review of the documentation, and to ensure that HSAG was using complete and accurate information in preparing this annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS's documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the data and information.

HSAG provided monthly written status reports to AHCCCS that described HSAG's progress in completing each of the major work plan activities critical to preparing the annual report. HSAG provided a first draft of this annual quality review report to AHCCCS for its review and comment on April 21, 2008.

Findings, Conclusions, and Recommendations About Timeliness, Access, and Quality of Care

The following section discusses Contractors' performance regarding the three BBA-defined aspects of care (i.e., timeliness of care, access to care, and quality of care). The findings are presented within the context of the three activities AHCCCS conducted and for which it provided the results to HSAG for its analysis and preparation of this report: conducting a review of Contractor performance for organizational assessment and structure standards, calculating and reporting

Contractor performance rates for State-selected measures, and calculating and reporting Contractor results for AHCCCS-mandated PIPs. Each section presents the overall outcomes of each activity across the Acute Care and the DES/CMDP Contractors.

Organizational Assessment and Structure Standards

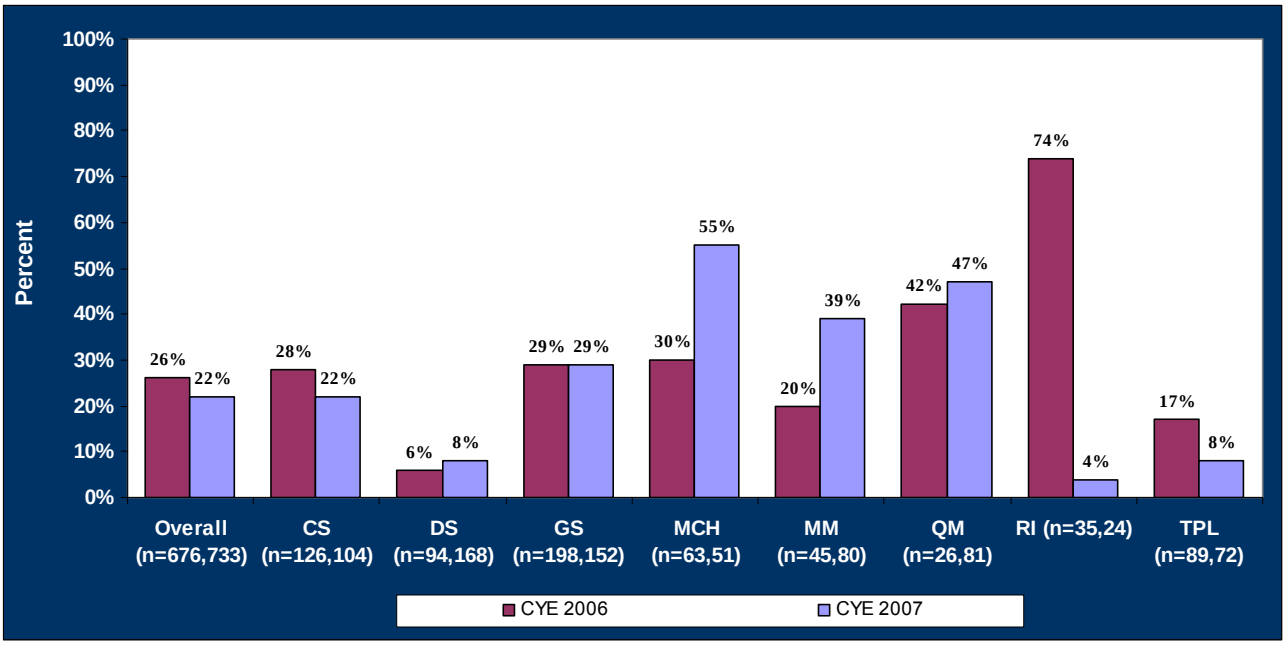
AHCCCS conducted an OFR for eight Acute Care Contractors and for the DES/CMDP Contractor. AHCCCS reviewed the Acute Care and DES/CMDP Contractors' performance in complying with 148 to 157 standards, depending on the Contractor.[1-1] Because AHCCCS conducted an extensive review of the organizational assessment and structure standards in both contract year ending (CYE) 2006 and CYE 2007, the findings, conclusions, and recommendations in this report are based on both current performance and the change in performance during the past two review periods.

Findings

Based on AHCCCS's review findings and assessment of the degree to which the Contractor complied with the standards, AHCCCS assigned the applicable performance designation to the Contractor's performance. *Full Compliance* was 90 to 100 percent compliant, *Substantial Compliance* was 75 to 89 percent compliant, *Partial Compliance* was 50 to 74 percent compliant, and *Non-Compliance* was 0 to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an *N/A* designation. When AHCCCS evaluates performance for a standard as less than fully compliant, it requires the Contractor to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, and then implement the corrective actions. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced.[1-2] This situation occurred 14 times among the Contractors. With different numbers of required standards across Acute Care and DES/CMDP Contractors, and the presence of CAPs for some standards in full compliance, the most valid method for comparing results was through the percentage of reviewed standards that required a CAP. The overall proportion of standards across all Acute Care and DES/CMDP Contractors with a required CAP and the proportion for each category of standards reviewed are shown in Figure 1-1.

[1-1] Differences in the number of standards reviewed were due to some standards being not applicable to specific Contractors.
[1-2] Full compliance is noted when 90 to 100 percent of all required aspects of a standard are in compliance. As such, any portion of the standard not in compliance could still require a CAP.

Figure 1-1—Two-Year Comparison of the Percentage of Standards With a CAP by Category For All Acute Care and DES/CMDP Contractors[1-3]



Note: Parenthetical numbers represent the total number of standards reviewed in CYE 2006 (first number) and CYE 2007 (second number). Only those categories evaluated in both contract years are presented in this figure.

Overall, Figure 1-1 illustrates that improvement was seen for the comparable categories of organizational assessment and structure standards. The total percentage of standards that required a CAP decreased from 26 percent (CYE 2006) to 22 percent (CYE 2007). The 4 percent drop represents a 15 percent relative improvement, although it only approached statistical significance (p=.083). However, while this finding suggests improvement across all Contractors, systemwide opportunities for improvement were also observed since approximately one in every five reviewed standards required a CAP.

The greatest improvement was seen in the Reinsurance category. The percentage of CAPs required for Reinsurance fell from 74 percent in CYE 2006 to just 4 percent in CYE 2007, a statistically significant difference (p<.001). This improvement demonstrates the extent of improvement that is possible within the span of a single review cycle and with aggressive and targeted improvement activities. However, caution should be used when interpreting this result due to the comparatively small number of standards; there were only four standards in CYE 2006 and three standards in CYE 2007. Conversely, the largest increase in the number of required CAPs was noted in the Maternal/Child Health category. The percentage of required CAPs in this category significantly increased 25 percentage points from 30 percent in CYE 2006 to 55 percent in CYE 2007 (p=.008). The Medical Management category also exhibited a statistically significant increase (p=.031) of 19 percentage points between CYE 2006 and CYE 2007 (from 20 percent to 39 percent, respectively).

[1-3] The category abbreviations are as follows: CS=Claim Systems, DS=Delivery System, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, QM=Quality Management, RI=Reinsurance, TPL=Third Party Liability.

The number of required CAPs for the Quality Management category remained comparatively high (42 percent in CYE 2006 and 47 percent in CYE 2007). Due to changes in the number of standards reviewed (CYE 2006 = 3; CYE 2007 = 11), comparability in rates is somewhat limited.

A comparison of the CAPs across compliance standard categories by Contractor highlights general areas for quality improvement. Table 1-1 presents the total number of CAPs required for each Contractor and for each category of standards. However, due to differences in the number of standards reviewed for each Contractor, caution should be used when interpreting differences in the total number of CAPs required.

Table 1-1—Number and Percentage of CAPs by Category and Acute Care and DES/CMDP Contractor[1-4]

Category	APIPA	Care1st	HCA	MHP	MCP	PHS	PHP	UFC	DES/ CMDP
Behavioral Health	1 (10%)	0 (0%)	2 (20%)	4 (40%)	2 (20%)	2 (20%)	6 (60%)	4 (40%)	3 (30%)
Claim Systems	3 (23%)	4 (31%)	1 (8%)	2 (15%)	2 (15%)	2 (15%)	0 (0%)	4 (31%)	5 (42%)
Cultural Competency/ Limited English Proficiency	6 (60%)	3 (30%)	1 (10%)	3 (30%)	1 (10%)	0 (0%)	0 (0%)	3 (30%)	1 (10%)
Delivery System	9 (43%)	1 (5%)	2 (10%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)
Encounters	2 (17%)	1 (9%)	3 (25%)	6 (55%)	1 (8%)	3 (25%)	0 (0%)	0 (0%)	4 (36%)
General Administration	5 (29%)	4 (24%)	2 (12%)	1 (6%)	0 (0%)	0 (0%)	1 (6%)	1 (6%)	4 (24%)
Authorization & Denial/Grievance System	7 (37%)	4 (21%)	2 (11%)	5 (26%)	5 (26%)	8 (42%)	2 (11%)	5 (26%)	6 (32%)
Maternal/Child Health	6 (100%)	4 (67%)	3 (50%)	3 (50%)	2 (29%)	1 (14%)	0 (0%)	4 (57%)	5 (83%)
Medical Management	5 (50%)	5 (50%)	1 (10%)	1 (10%)	0 (0%)	7 (70%)	2 (20%)	1 (10%)	9 (90%)
Member Services	0 (0%)	0 (0%)	1 (7%)	2 (13%)	1 (7%)	0 (0%)	0 (0%)	2 (13%)	2 (15%)
Quality Management	8 (15%)	5 (50%)	5 (50%)	4 (40%)	3 (27%)	1 (10%)	6 (60%)	3 (30%)	3 (38%)
Reinsurance	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	0 (0%)	0 (0%)	0 (0%)
Third Party Liability	1 (11%)	1 (11%)	2 (22%)	0 (0%)	0 (0%)	0 (0%)	2 (22%)	0 (0%)	0 (0%)
Total # CAPs (Total % CAPs)[A]	**53 (34%)**	**32 (21%)**	**25 (16%)**	**31 (20%)**	**17 (11%)**	**25 (16%)**	**19 (12%)**	**27 (17%)**	**43 (29%)**

[A] Comparisons between the total number of CAPs should be interpreted with caution due to differences in the number of standards associated with each Contractor. However, the total percentage of CAPs reflect for these differences and, therefore, can be compared across Acute Care and DES/CMDP Contractors.

[1-4] The Contractors' names are abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health System, PHP=Phoenix Health Plan/Community Connections, UFC=University Family Care, Arizona Department of Economic Security/Comprehensive Medical and Dental Plan=DES/CMDP.

Overall, the percentage of CAPs required during the current review period ranged from 11 percent (MCP) to 34 percent (APIPA). This result highlights considerable variation among the Contractors.

Conclusions

In general, the percentage of reviewed standards that required a CAP appeared to decrease (p=.083). While performance for some compliance categories of standards exhibited increases in the number of required CAPs, large proportional improvements were also seen for several categories. For example, performance for the Reinsurance category moved from having the highest percentage of CAPs in CYE 2006 (74 percent) to having only one required CAP in CYE 2007 (4 percent). However, caution should be used when interpreting this result due to the comparatively small population size (n=4). This finding demonstrates the degree of change within a category that is possible to achieve within one reporting year. The level of effort and strategic interventions behind this change should be focused on the Maternal/Child Health, Medical Management, and Quality Management categories next, where continued opportunities for improvement were indicated.

Recommendations

The greatest opportunities for improvement across the Acute Care and DES/CMDP Contractors were seen for the Maternal/Child Health and Medical Management categories. Both categories exhibited statistically significant declines in performance since the previous review period. Additionally, the overall percentage of required CAPs was comparatively high for the Quality Management category. At 47 percent, the Quality Management category was the second-highest category, next to the Maternal/Child Health category (55 percent), in the number of required CAPs.

- **Maternal/Child Health**: Although all Acute Care Contractors provided required services to pregnant women, five Contractors did not have effective systems in place to monitor maternity program outreach activities. The standards least in compliance across the Contractors were those related to coordination with the Arizona Early Intervention Program (AzEIP); implementation of the Parents' Evaluation of Developmental Status (PEDS) tool, including appropriate and accurate training for providers; and effective monitoring of referrals to family planning services to ensure all members have appropriate access to services. All of these areas represent opportunities for improvement. Contractors should consider establishing multidisciplinary work groups to evaluate the effectiveness of their maternal and child health policies and procedures to ensure that they clearly communicate performance expectations for staff and providers. The policies and procedures should also describe the Contractors' monitoring activities and their frequency. The work groups should also engage in a root-cause analysis of the factors most significantly contributing to the failure to comply with the contract requirements. Based on the findings from these activities, Contractors should identify and implement targeted interventions to bring their performance into alignment with AHCCCS requirements.
- **Medical Management**: In general, the poor performance by three Contractors had a negative impact on the overall statewide percentage of standards that required a CAP in this category. One standard in particular presented an overarching problem for the Contractors—i.e., "The Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards." While requirements were addressed in written policies and procedures, the Contractors had not yet effectively operationalized and implemented them within their organizations. Contractors should explore and resolve the factors contributing to their

failure to implement their policies and processes and ensure that when conducting an evaluation of all new technologies, their evaluation processes comply with AHCCCS standards.

- **Quality Management**: Underlying the lack of compliance in the Quality Management category was the Contractors' unsuccessful translation of quality management research, best practices, and monitoring findings into viable and effective improvement interventions. For example, this finding was reflected in the lack of Quality Management meeting minutes that documented discussions of Contractors' current CAPs, proposed interventions, and timelines for implementation. In addition, performance for standards related to ongoing organizational credentialing and the effective monitoring of interventions developed as a result of member complaint/abuse issues continue to represent opportunities for improvement among Contractors. As a result, it is recommended that Contractors evaluate causal factors (e.g., organizational and structural, monitoring processes/frequencies, department/committee accountabilities, etc.) contributing to their continued failure to fully comply with the standards. The results of the evaluation should identify the areas for strategically targeting improvement activities and tighter Contractor oversight and intervention with regard to staff and/or provider performance results.

Performance Measures

AHCCCS collected data and calculated and reported Contractor performance for a set of AHCCCS-selected performance measures in both the previous and current reporting periods. As a result, the findings, conclusions, and recommendations are based on current Contractor performance and the change in performance over the two most recent reporting periods. However, due to changes in AHCCCS's minimum performance standards (MPSs) and goals for nearly all measures between the two years, the two-year comparisons are somewhat limited.

Findings

Table 1-2 presents the mean performance measurement rates across the nine Acute Care and DES/CMDP Contractors. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, and AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks.

Table 1-2—Performance Measurement Review *for* Acute Care and DES/CMDP Contractors							
Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005 to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs[E] (Total)	78.3%	**75.8%**	**-3.3%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	84.9%	**81.0%**	**-4.6%**	**p<.001**	85%	86%	97%
25 Months–6 Years	77.1%	**75.4%**	**-2.2%**	**p<.001**	78%	80%	97%
7–11 Years[C]	76.8%	**74.1%**	**-3.5%**	**p<.001**	77%	79%	97%
12–19 Years[C]	78.9%	**75.9%**	**-3.7%**	**p<.001**	79%	81%	97%
Adults' Preventive/Ambulatory Care (Total)[D]	79.2%	79.5%	0.4%	p=.081	N/A[B]	N/A[B]	N/A[B]
20–44 Years[D]	77.3%	77.3%	0.0%	p=.885	78%	80%	96%
45–64 Years[D]	83.4%	**84.1%**	**0.8%**	**p=.020**	83%	84%	96%
Well-Child Visits—First 15 Months[D]	54.0%	**58.0%**	**7.3%**	**p<.001**	70%	72%	90%
Well-Child Visits—3,4,5,6 Years	58.3%	58.5%	0.4%	p=.514	56%	58%	80%
Adolescent Well-Care Visits	33.1%	32.8%	-0.9%	p=.201	37%	38%	50%
Annual Dental Visit	58.2%	**59.6%**	**2.4%**	**p<.001**	51%	57%	57%
EPSDT Participation	69.7%	**65.0%**	**-6.6%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrate the statistical significance between the performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCPs and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of the aggregate level, as they were in CYE 2006.

[C] Due to a change in management, Maricopa Health Plan members were not included in the current measurement.

[D] DES/CMDP was not included in the current measurement.

[E] AHCCCS updated its programming for the Children's Access to PCPs measure in order to better conform to current HEDIS methodology. These updates may have resulted in a decline in the rates for these measures.

Using AHCCCS's CYE 2007 MPS, goals, and long-range benchmarks as frames of reference, the Acute Care and DES/CMDP Contractors showed considerable opportunity for continued improvement as only 27 percent of the reported measures with identified standards met or exceeded AHCCCS's MPS. Additionally, Table 1-2 shows that overall performance dropped between the two most recent review periods. In total, 7 of the 13 measures decreased with 6 of the measures exhibiting statistically significant (p< .001) declines in performance (Children's Access to PCPs and EPSDT [Early and Periodic Screening, Diagnosis, and Treatment program] Participation). However, declines in the Children's Access to PCPs measure may have resulted from programming changes implemented during the current measurement period. Of the remaining six reported measures, three showed statistically significant (p=.020 or less) increases in performance (Adults' Preventive/Ambulatory Care—45 to 64 years, Well-Child Visits—First 15 Months, and Annual Dental Visit). Overall, the average across all performance measures suggests a small decline from 69.9 percent (CYE 2006) to 69.0 percent (CYE 2007), although statistical testing was not done for the overall average. This finding is further supported in Table 1-3.

Table 1-3 presents the number of required CAPs for Acute Care and DES/CMDP Contractors during CYE 2006 and CYE 2007 for comparable performance measures during both reporting periods.[1-5] The table shows each of the performance measures, the previous number of CAPs required, the CYE 2006 MPS, the current number of CAPs required, and the CYE 2007 MPS. The MPS increased for four of the five measures presented in the table. Although the changes to the MPS could impact the number of CAPs required, Contractors are expected to implement quality improvement efforts that are at least commensurate with the increases in MPS rates.

Table 1-3—Performance Measures—Corrective Action Plans Required *for* Acute Care and DES/CMDP Contractors

	CYE 2006		CYE 2007	
Performance Measure	Number of CAPs (10/1/04–9/30/05)	AHCCCS Minimum Performance Standard	Number of CAPs (10/1/05–9/30/06)	AHCCCS Minimum Performance Standard
Well-Child Visits—First 15 Months[A]	7	70%	7	70%
Well-Child Visits—3, 4, 5, 6 Years	1	55%	6	56%
Adolescent Well-Care Visits	3	32%	7	37%
Annual Dental Visit	0	49%	0	51%
EPSDT Participation	0	58%	6	68%
Total Performance Measure CAPs	**11**		**26**	

[A] Maricopa Health Plan and DES/CMDP were not included in this measure.

Table 1-3 highlights three primary findings from this review. First, the current review cycle saw a marked increase in the number of required CAPS for the five comparable measures across Acute Care and DES/CMDP Contractors, increasing from 11 CAPs in CYE 2006 to 26 CAPs in CYE 2007. This increase of 15 CAPs represents a 136.4 percent increase in the opportunities for improvement found overall across Acute Care and DES/CMDP Contractors. Second, the number of required CAPs increased for the Well-Child Visits—3, 4, 5, 6 Years; Adolescent Well-Care visits; and EPSDT Participation measures, but remained constant for Well-Child Visits—First 15 Months. Third, the Annual Dental Visit measure was the only measure to remain without a CAP. DES/CMDP had no required CAPs in CYE 2007. The next-lowest number of CAPs was six CAPs required for two Acute Care Contractors.

Figure 1-2 presents the weighted average rates for the performance measures for Acute Care and DES/CMDP Contractors. The figure presents the CYE 2006 and CYE 2007 performance measure rates averaged across 11 of the 13 performance measures shown in Table 1-2. The Children's Access to PCPs (Total) and Adult's Access to Preventive/Ambulatory Care (Total) measures were excluded from the weighted average calculation since these rates include the individual age-specific rates.

[1-5] In CYE 2006, the AHCCCS MPSs, goals, and long-range benchmarks for the Children's Access to PCPs and Adults' Preventive/Ambulatory Care measures were established at the aggregate level. However, in CYE 2007, AHCCCS redefined performance standards for these measures at the age group level. As a result, comparisons of the number of CAPs for these measures are not possible.

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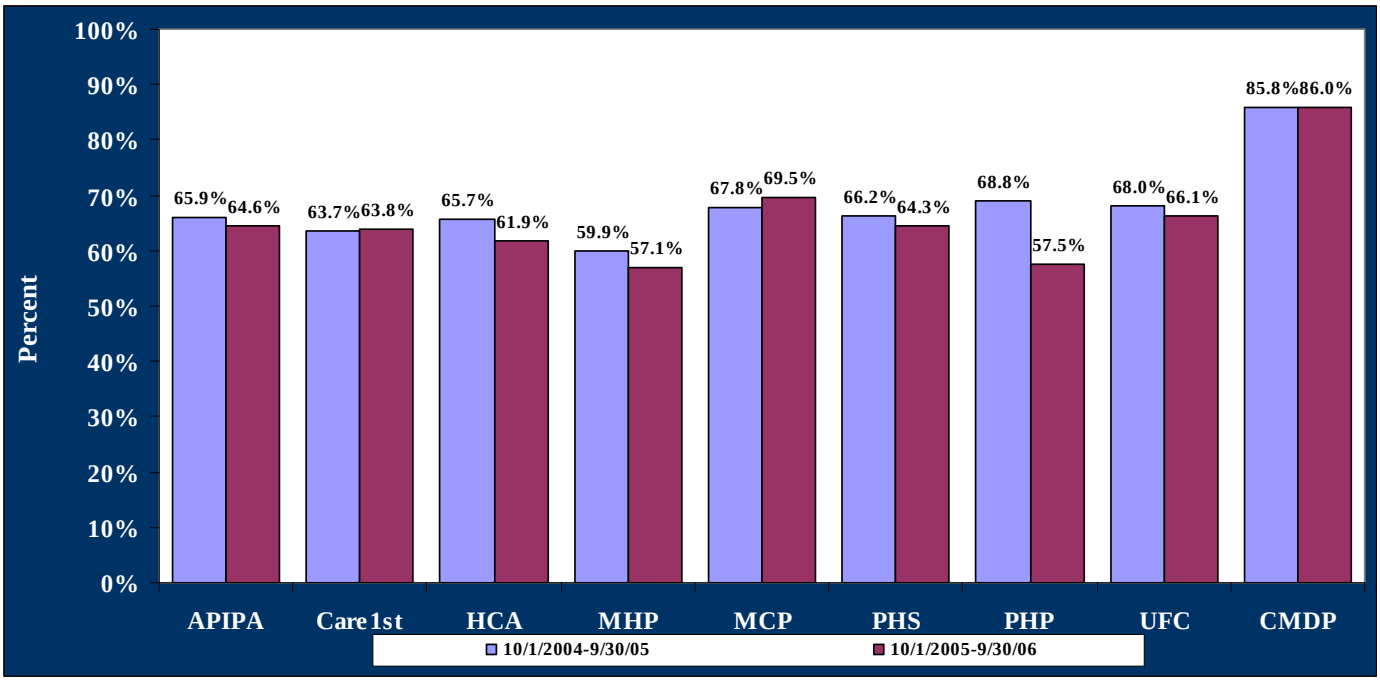
Figure 1-2—Current and Previous Average Performance Measure Rates *for* Acute Care and DES/CMDP Contractors[1-6]



Note: The overall weighted average for the DES/CMDP Contractor includes fewer measures than for the Acute Care Contractors. The Adult's Access to Preventive/Ambulatory Care measure was not included in the overall weighted average for the DES/CMDP Contractor.

In general, Figure 1-2 shows overall rate declines for six of the nine Acute Care and DES/CMDP Contractors over the two most recent measurement periods. These declines ranged from 1.3 percentage points to 11.4 percentage points. The largest increase among the three Contractors showing an increase in rates was only 1.7 percentage points, indicating minimal overall change.

Conclusions

With a few exceptions (Adults' Preventive/Ambulatory Care—45 to 64 years, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, and Annual Dental Visits), the entire performance measures domain represents a statewide opportunity for improvement. Only DES/CMDP's performance met or exceeded AHCCCS's MPS, resulting in no CAPs required for the CYE 2007 review. Acute Care Contractors' results were below the organizational expectations set by AHCCCS and suggest the need to implement continuous improvement methodologies throughout their organizations. Additionally, since most changes in the reported rates were negative, the current review did not show indications of improvement. Instead, the results strongly indicated high-priority opportunities for improvement.

[1-6] The Contractors' names are abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health Service, PHP=Phoenix Health Plan, UFC=University Family Care, Comprehensive Medical and Dental Program=DES/CMDP.

AHCCCS continues to foster improvement in Contractor performance through a comprehensive system of incentives. Since 2003, AHCCCS has posted individual Contractor performance measure rates on the AHCCCS Web site in order to incentivize Contractors to improve their rates. AHCCCS has also modified its auto-assignment algorithm based on demonstrated improvement. Additionally, when Contractors do not meet MPSs, they are required to develop, implement, monitor, and evaluate CAPs designed to bring performance measure rates up to, and ideally above, the AHCCCS MPS. If a Contractor does not demonstrate improvement, a Notice to Cure is then sent to that Contractor. AHCCCS also regularly evaluates and increases the MPS in order to push continuous improvement among Contractors.

Recommendations

The Contractors' quality improvement efforts for the performance measures did not yield the desired results. Overall, for comparable performance measures, the number of required CAPs increased in CYE 2007. In total, 65 CAPs were required during the current measurement period by the Acute Care Contractors. As such, continuing the current quality improvement activities are unlikely to result in a substantive change in performance measure rates in the near future. Instead, it is recommended that each Acute Care Contractor conduct a barrier analysis that focuses on the relationship between its structural access parameters (e.g., numbers and distributions of various types of providers, hours of operation, member and provider appointment-reminder systems, enhanced member and provider education, and enhanced transportation options for members) and the performance measures requiring a CAP. The results should point to additional targeted interventions (i.e., enhancing or redesigning current and/or adding new improvement activities). Contractors should then operationalize and monitor the effect of these interventions using rapid-cycle methodologies for both processes.

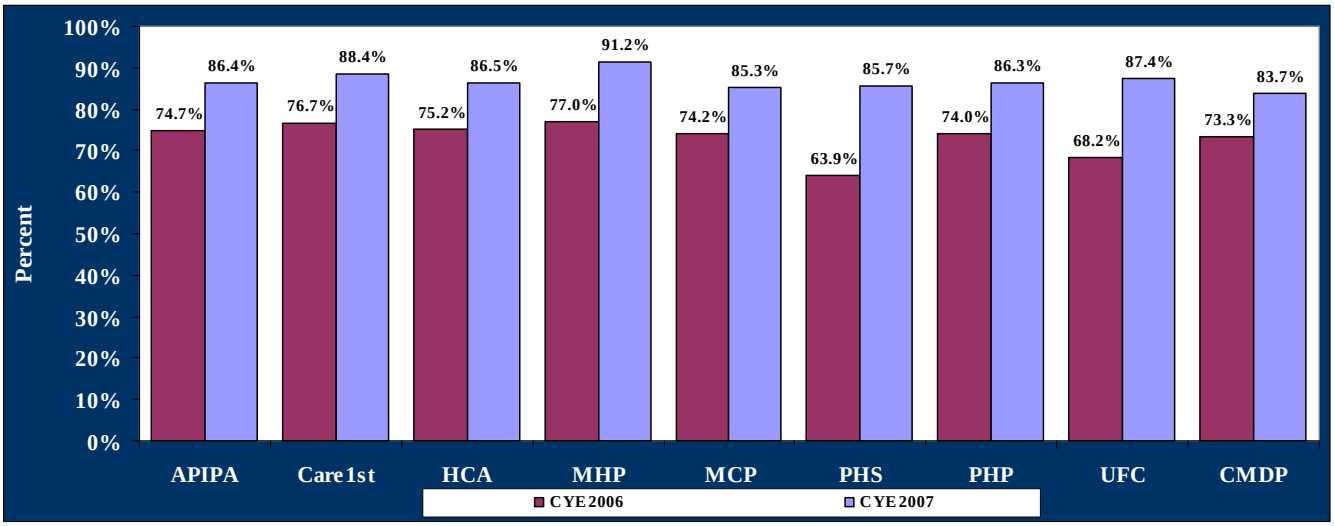
Performance Improvement Projects (PIPs)

AHCCCS provided to HSAG the results it calculated for the Acute Care and DES/CMDP Contractors for their AHCCCS-mandated PIPs. The PIPs were in the remeasurement phase and the remeasurement data for all contractors was from October 1, 2006, to September 30, 2007. One PIP was required during the current review period for all Contractors—Provider Reporting to the Arizona State Immunization Information System (ASIIS)—and it was in the first remeasurement year. Additionally, two other PIPs were required for specific Contractors that failed to meet AHCCCS's requirements to complete the PIPs during the previous reporting period. These PIPs included Children's Oral Health (third remeasurement, October 1, 2005, through September 30, 2006) for Maricopa Health Plan and Health Choice Arizona, and Immunization Completion Rates by 24 Months of Age (second remeasurement, October 1, 2004, through September 30, 2005) for Phoenix Health Plan and Health Choice Arizona.

Findings

Figure 1-3 presents a two-year comparison of Contractor rates for the Provider Reporting to ASIIS PIP. The figure presents the previous and current rates for each Acute Care and DES/CMDP Contractor.

Figure 1-3—Two-Year Comparison of ASIIS Reporting Rates *for* Acute Care Contractors and DES/CMDP[1-7]



The Provider Reporting to ASIIS PIP is showing signs of becoming a successful PIP. Each of the Contractors returned highly significant results ($p < .001$ each) during the first remeasurement period, with increases that ranged from 10.4 to 21.8 percentage points. Overall, the range in rates increased, moving from 63.9 percent to 77.0 percent during the baseline measurement period and from 83.7 percent to 91.2 percent during the remeasurement period. This finding highlights that the lowest remeasurement rate was higher than the highest rate at baseline.

Regarding the Children's Oral Health PIP, both HCA and MHP exhibited changes in rates during the third remeasurement period, although none was statistically significant. HCA's rates changed from 57.6 percent in CYE 2006 to 58.4 percent in CYE 2007 (p=.173) while MHP's rates fell from 58.8 percent in CYE 2006 to 57.9 percent in CYE 2007 (p=.350). However, only MHP's results exhibited sustained improvement, as noted by the nonsignificant decrease in rates. HCA's rate continued to remain below its first remeasurement rate.

Performance on the Immunization Completion Rate PIP was mixed for the two Contractors required to complete a second remeasurement. HCA exhibited a statistically significant increase of 12.4 percent (p<.001) between the first and second remeasurement periods while PHP's rates fell. Specifically, HCA's rate increased significantly (p<.001) from 50.3 percent to 62.7 percent, and PHP's reported rate decreased significantly (p=.020) to 76.5 percent from 82.5 percent in the previous remeasurement period.

Conclusions

Results on the Provider Reporting to ASIIS PIP showed considerable improvement in the rates for all Acute Care and DES/CMDP Contractors. With an additional year to continue and/or further strengthen interventions, the Contractors' performance should continue to return sustained results that are highly valid rates for immunization reporting compliance. Additionally, while results were

[1-7] The Contractors' names are abbreviated as follows: APIPA= Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health System, PHP=Phoenix Health Plan, UFC=University Family Care, Comprehensive Medical and Dental Program = DES/CMDP.

varied on the Children's Oral Health and Immunization Completion Rate PIPs for those Contractors required to complete remeasurements, only one Contractor exhibited sustained improvement.

Key Contractor interventions for the Provider Reporting to ASIIS PIP included educating provider office staff and conducting ongoing monitoring of provider compliance with reporting requirements. The AHCCCS Clinical Quality Management staff worked collaboratively with the Contractors to develop program-wide intervention and improvement strategies. Upon conducting a root cause analysis, the collaborative identified many areas for improvement. AHCCCS and the Contractors worked together to target providers and use common materials and information to educate providers on ASIIS. In most cases, noncompliant staff in providers' offices were contacted personally by the Contractor's staff. The focus of these contacts was to troubleshoot individual provider problems affecting timely and accurate reporting to ASIIS. These Contractor-initiated contacts also served the purpose of reinforcing with providers the importance of ASIIS reporting, as well as the AHCCCS- and Contractor-mandated contract requirement.

Recommendations

In light of the Contractors' overall excellent Provider Reporting to ASIIS PIP results, no recommendations are offered at this time. All Contractors should work to sustain their level of improvement in subsequent remeasurements.

Overall Findings, Conclusions, and Recommendations

Acute Care and DES/CMDP Contractors are making progress toward improving the delivery of services and quality of care provided to their members. This conclusion is evidenced through the Contractors' performance results for the three activities AHCCCS conducted and HSAG analyzed and included in this report. Using operational and financial reviews and measuring Contractor performance on AHCCCS-selected measures and PIPs to guide and facilitate improvement, AHCCCS has implemented a comprehensive system to monitor and improve the timeliness of, access to, and quality of care Contractors provide to Medicaid members.

Overall, improvement was noted within the organizational assessment and structure standards and PIP portions of the current annual review. Within the organizational assessment and structure standards, the overall number of CAPs required for comparable standards decreased from 26 percent (CYE 2006) of the reviewed standards to 22 percent (CYE 2007). However, these results were somewhat tempered by the finding that improvements were seen for only three of the eight continuing compliance standard categories (Claims Systems, Reinsurance, and Third Party Liability). Increases in the percentage of standards not in full compliance were noted for four of the remaining categories, with performance in the Authorization and Denial/Grievance System category remaining unchanged. On a commendable and positive note, statewide performance showed improvement for the Reinsurance category. Contractor performance for this category moved from having the highest percentage of required CAPs in CYE 2006 (74 percent) to having only one required CAP in CYE 2007 (4 percent). This result demonstrates the amount of change within a category that is possible to achieve within the span of one review cycle, in addition to highlighting the effectiveness of AHCCCS's monitoring system and the strategic and effective improvement activities implemented by the Contractors. However, caution should be used when interpreting this

result due to the comparatively small number of standards; there were only four standards in CYE 2006 and three standards in CYE 2007.

Based on current performance, the overall focus of Contractors' required CAPs targeted the Maternal/Child Health, Medical Management, and Quality Management categories. The standards within these areas, in particular, are designed to ensure member access to timely, quality care by having appropriate Contractor administrative structures, performance monitoring, and feedback systems in place. AHCCCS's regular monitoring and requirement for CAPs directs Contractor quality improvement efforts to the highest-priority performance improvement areas.

For the PIPs, the Provider Reporting to ASIIS PIP results demonstrated substantive improvements in the rates presented by each Contractor. With another year to continue and/or strengthen interventions, Contractor performance for this PIP should be able to return highly valid rates for immunization reporting compliance. Additionally, while results were varied on the Children's Oral Health and Immunization Completion Rate PIPs for those Contractors required to complete remeasurements, only one Contractor exhibited sustained improvement. Through the strategic use of PIPs, AHCCCS Contractors are continually improving member access to timely, quality care.

Considerable opportunities for improvement continued for the Contractors' performance measure rates. Overall, declines in performance were noted for six of the nine Contractors. However, it should be noted that modifications to some indicator methodologies may have affected reported rates negatively. AHCCCS issued numerous Notices to Cure outlining the possibility for sanctions if Contractors did not improve their performance measure rates. As part of its oversight and ongoing monitoring, AHCCCS required low-performing Contractors to evaluate current interventions and implement new interventions as appropriate. Additionally, the current review cycle saw a marked increase in the number of required CAPs for the five comparable measures across Contractors. The number of CAPs increased from 11 CAPs in CYE 2006 to 26 CAPs in CYE 2007. This increase of 15 CAPs represents a 136.4 percent increase in the opportunities for improvement across all Contractors. However, caution should be used when interpreting these results since changes in the MPS between measurement years may have affected the number of CAPs required for Contractors.

Statewide, recommendations include focusing efforts to improve the performance of Contractors across the entire domain of performance measures, except for Annual Dental Visits, which has not had a required CAP during the past two measurement periods. Overall, the measures requiring a CAP represent access-to-care issues that can also impact the timeliness and quality of care. For this reason, Contractors should consider strategies such as expanding provider networks where needed and increasing access through extended hours and transportation.

In general, this 2006–2007 Annual Report for Acute Care and DES/CMDP Contractors has shown some improvements in the timeliness of, access to, and quality of care provided to Medicaid members. While several opportunities for improvement are highlighted throughout the report, the opportunities and the associated recommendations should not detract from the improvements and progress some Contractors have made.

2. Background

This section of the report includes a brief history of the AHCCCS Medicaid managed care programs and a description of AHCCCS's Quality Assessment and Performance Improvement (QAPI) Strategy. The description of the QAPI strategy summarizes AHCCCS's:

- Quality strategy goals and objectives.
- Operational performance standards used to evaluate Contractor performance in complying with BBA regulations and State contract requirements.
- Requirements and targets AHCCCS used to evaluate Contractor performance on AHCCCS-selected measures and to evaluate the validity of and improvements achieved through the Contractors' AHCCCS-required PIPs.

History of the AHCCCS Medicaid Managed Care Program

AHCCCS, the first statewide Medicaid managed care system in the nation, has operated under an 1115 Research and Demonstration Waiver since 1982, when it began its Acute Care Program. The Arizona Long Term Care System (ALTCS) program was added in December 1988 for individuals with developmental disabilities and then further expanded in January 1989 to include the elderly and physically disabled (EPD) populations. Coverage of comprehensive behavioral health services began in October 1990 for seriously emotionally disabled (SED) children younger than 18 years of age who required residential care. Under its last expansion, all Medicaid-eligible individuals now have comprehensive behavioral health coverage. AHCCCS has operated throughout its 25-year history as a pioneer and recognized, respected leader in developing and managing innovative, quality, and cost-effective Medicaid managed care programs.

AHCCCS contracts with private and public managed care organizations (MCOs) and two prepaid inpatient health plans (PIHPs) to provide services to its members statewide. The two PIHPs are each contracted to provide a defined and limited scope of services (i.e., one provides behavioral health services and the other provides children's rehabilitation services). Within the AHCCCS program, the MCOs and the PIHPs are called "Contractors."

AHCCCS Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and §438.202 implement Section 1932(c)(1) of the Act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) must meet. The Medicaid state agency must, in part:

- Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the state that are consistent with the federal Medicaid managed care regulations.
- Update the strategy periodically as needed.
- Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

While AHCCCS has had a formal QAPI plan since 1994, it established and submitted its initial quality strategy to CMS in 2003. It has continued to update the strategy as needed and to submit revisions to CMS. AHCCCS's QAPI strategy was last revised and forwarded to CMS in December 2007.

AHCCCS administration oversees the overall effectiveness of its QAPI strategy with several divisions/offices within the agency sharing management responsibilities. For specific initiatives and issues, AHCCCS may also involve other internal and/or external collaborations/participants.

Quality Strategy Objectives

AHCCCS's mission is "Reaching across Arizona to provide comprehensive, quality health care to those in need." Consistent with this mission, AHCCCS states in its quality strategy that:

- AHCCCS develops the strategy through identifying specific goals and objectives.
- The quality strategy provides a framework for AHCCCS's overall goal of improving and/or maintaining the members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions.
- The overarching quality strategy objective is to design and implement "a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement ... designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of services."

The quality strategy objectives are one component of the agency's five-year strategic plan. AHCCCS's strategies for evidence-based outcomes and quality initiatives address its broad quality goals and objectives and include:

- Rewarding quality of care, member safety, and member satisfaction outcomes.
- Supporting best practices in disease management and preventive care.
- Providing feedback on quality and outcomes to Contractors and providers.
- Providing comparative information to consumers.

AHCCCS's QAPI strategy describes detailed goals and objectives that address, in part:

- Enhancing performance measure, performance improvement, and best practice activities as one approach to developing a statewide QAPI roadmap for driving improvement in member-centered outcomes.
- Building upon prevention efforts and health maintenance/management to improve members' health status through targeted medical management.
- Developing collaborative strategies and initiatives with State agencies and other partners to improve access, health outcomes, and health education; manage vulnerable and at-risk members; and build professional and paraprofessional capacity in underserved areas.
- Enhancing customer service.
- Improving information retrieval and reporting capacity.

Operational Performance Standards

The Assessment section of AHCCCS's QAPI strategy describes the processes AHCCCS uses to assess the quality and appropriateness of care/services for members with routine and special health care needs. The assessment processes include, but are not limited to, conducting annual OFRs of Contractors and reviewing their deliverables required by contract, program-specific performance measures, and performance improvement projects. AHCCCS conducts OFRs and reviews Contractor deliverables to meet the requirements of Medicaid managed care regulations (42 CFR §438.364). AHCCCS also conducts the reviews to determine the extent to which each Contractor complied with additional federal and State regulations as well as AHCCCS contract requirements and policies. As part of the OFRs, AHCCCS staff review Contractor progress in implementing recommendations made during prior OFRs and determines each Contractor's compliance with its own policies and procedures.

At least every three years, AHCCCS reviews Contractor performance in complying with standards in all 14 performance areas to ensure Contractor compliance with BBA requirements and AHCCCS contract standards. AHCCCS may review some areas more frequently—sometimes annually—if the requirements are new, there are Contractor compliance issues, or the requirements are in an area of special focus. AHCCCS issues a performance report to each Contractor that includes AHCCCS's findings and the Contractor's scores for each standard AHCCCS reviewed in each performance area. The scores define the degree to which the Contractor's performance is in compliance with the requirements, i.e., *Full Compliance* (90–100 percent), *Substantial Compliance* (75–89 percent), *Partial Compliance* (50–74 percent), *Non Compliance*, (0–49 percent). If a standard is not applicable for a Contractor, AHCCCS notes this using an *NA* designation. AHCCCS also documents its recommendations to improve Contractor performance. For AHCCCS recommendations stated as the Contractor "*must*" or the Contractor "*should*" ... AHCCCS requires Contractors to submit detailed CAPs to AHCCCS for its review and acceptance.

The performance areas AHCCCS evaluates are:

- Behavioral Health
- Case Management
- Claims Systems
- Corporate Compliance

- Cultural Competency
- Delegated Agreements
- Delivery System
- General Administration
- Grievance System
- Maternal and Child Health
- Medical Management
- Quality Management
- Reinsurance
- Third Party Liability

For the 2006–2007 OFR, AHCCCS initiated a new three-year cycle of OFRs and evaluated Contractor performance in 13 areas.

Examples of deliverables that Contractors are required to submit to AHCCCS for its review include, but are not limited to, the following:

- Annual Case Management Plan
- Annual Cultural Competency Evaluation
- Annual EPSDT Plan (including dental)
- Annual Medical Management Plan and Evaluation
- Annual Network Development and Management Plan
- Annual Quality Management Plan and Evaluation
- Quarterly EPSDT Progress Reports
- Quarterly Quality Management Reports

Performance Measure Requirements and Targets

AHCCCS's quality strategy describes the agency's processes to define, collect, and report Contractor performance data on AHCCCS-required measures. AHCCCS uses the Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]) for most of its performance measures. Examples of measures for any given year could include breast and cervical cancer screening, adolescent well-care visits, childhood immunizations, and timely initiation of services, including prenatal services. AHCCCS annually establishes a minimum performance standard (MPS), goal, and long-range benchmark for each measure. Contractors not meeting the MPS for any given measure are required to submit to AHCCCS corrective action plans (CAPs) that include the Contractors' planned interventions that will assist them in meeting the MPS.

For the measurement year ending September 30, 2006, AHCCCS collected and calculated the Acute Care and DES/CMDP Contractors' performance rates for the following measures:

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Children's Access to Primary Care Practitioners (12–24 months, 25 months–6 years, 7–11 years, and 12–19 years)
- Adults' Access to Preventive/Ambulatory Health Services (20–44 years and 45–64 years)*
- Well-Child Visits in the First 15 Months of Life*
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Participation

* Not required for DES/CMDP

Performance Improvement Project Requirements and Targets

AHCCCS's QAPI strategy described the agency's requirements and processes to ensure that Contractors conduct PIPs, which the QAPI defined as "a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome"—i.e., to improve the quality of care and service delivery. AHCCCS encourages its Contractors to conduct PIPs that they select (e.g., increasing screening of blood levels for children and improving timeliness of prenatal care, which were underway when AHCCCS submitted to CMS its December 2007 QAPI strategy). However, AHCCCS also selects PIPs that the Contractors must conduct. The PIPs that the Acute Care and DES/CMDP Contractors must conduct during any given time period may or may not be the same as those that the ALTCS EPD and DES/DDD Contractors must submit. For example, AHCCCS required all Contractors to conduct a diabetes improvement PIP, which was completed in 2006 and resulted in improvements in preventative care and outcomes in the management of members diagnosed with diabetes. For 2007, the AHCCCS-required PIPs were not the same for all contractors

For the AHCCCS-mandated PIPs, AHCCCS and the Contractors measure performance for at least two years after Contractor baseline rates and interventions are implemented to show not only improvement, but also sustained improvement, as required by the BBA. While AHCCCS does not establish minimum performance targets for Contractors, it does require Contractors to demonstrate improvement and then sustain the improvement over at least one subsequent remeasurement cycle. AHCCCS requires Contractors to submit reports evaluating their data and interventions, and proposing new or revised interventions, if necessary.

AHCCCS-required PIPs for the Acute Care and the DES/CMDP Contractors that were under way for the period covered by this report included:

- *Improving the Completeness of Physician Reporting to the Arizona State Information System (ASIS)*
- *Children's Oral Health Dental Visit**
- *Immunization Completion Rates by 24 Months of Age**

* Applicable for only those Contractors that had not yet met AHCCCS requirements to complete this PIP (i.e., improved performance was not sustained over at least the required two-year remeasurement period.)

Mandatory Activities

As permitted by CMS and described in Section 1—Executive Summary, AHCCCS performed the functions associated with the three CMS-mandatory activities that must be performed for the State's Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plan (PIHP) contractors:

- Conduct reviews to determine contractor compliance with standards established by the State which are associated with the applicable federal and State regulations, statutes, rules, and contract requirements
- Validate contractor performance measures
- Validate contractor performance improvement projects (PIPs)

AHCCCS contracted with HSAG to aggregate and analyze the data AHCCCS obtained from conducting the activities for its Contractors and to prepare this CMS-required 2006–2007 external quality review annual report of findings and recommendations.

Optional Activities

AHCCCS's EQRO contract with HSAG did not require HSAG to conduct, or to analyze and report results and HSAG's conclusions from AHCCCS having conducted, any CMS-defined optional activities (e.g., validating encounter data, conducting focused studies of health care quality, and assessing information systems capabilities).

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

In its current quality strategy, AHCCCS states that:

- The EQR reports include detailed information about the EQRO's independent assessment process, results, and recommendations.
- AHCCCS uses the information to assess the effectiveness of its current strategic goals and strategies and to provide a roadmap for potential changes and new goals and strategies.

AHCCCS also uses the EQR report findings and recommendations to:

- Support the goals of the national Quality and Cost Transparency Initiatives and AHCCCS's continued development and implementation of its statewide Health Information Exchange and Electronic Health Record central repository (HIE-EHR) and a Web-based system to access and maintain the EHR. The applications are designed to make relevant and timely information

available to Medicaid beneficiaries and providers in a user-friendly format. When fully deployed, the HIE-EHR is expected to improve coordination of member care, enhance opportunities for self-management through personal health information and integrated wellness applications, improve quality of care oversight and transparency through timely performance information, and reduce both medical and administrative costs.

- Drive requirements contained in its Requests for (Contractors) Proposals (RFP) processes.
- Through publishing its EQR annual reports on AHCCCS's Web site, provide members, Contractors, and other stakeholders an opportunity to review and compare Contractor performance and, as applicable to newly enrolled AHCCCS members, to make informed Contractor-enrollment choices.

AHCCCS Statewide Quality Initiatives Across All Medicaid Managed Care Programs

AHCCCS has proven itself to be an innovative leader in identifying and aggressively, proactively pursuing opportunities to improve health care quality and outcomes, as seen in its mission, vision, 2007 QAPI strategy, and five-year strategic plan that began January 1, 2008.

AHCCCS's mission is: "Reaching across Arizona to provide comprehensive, quality health care for those in need." In its 2007 QAPI strategy, the agency describes its vision as "shaping tomorrow's managed health care...from today's experience, quality, and innovation." That vision includes:

- Advocating for customer-focused health care.
- Leading the development of new quality-of-care initiatives and quality improvement strategies.
- Continuing its roles as an innovator of health coverage and as a valued partner and collaborator in improving the health status of Arizonans.
- Expanding its role as a facilitator of collaborative health care initiatives that leverage public and private resources.
- Connecting uninsured and at-risk Arizonans to affordable health care coverage.
- Maintaining its role as a good steward of public and private health care finances.
- Increasing its role as a health information resource.
- Providing an optimal work environment for its employees.

Over time, AHCCCS administration has built its comprehensive quality structure by:

- Designing structures, programs, and initiatives that adhere to federal and State requirements.
- Continuously conducting environmental scans of applicable national standards and national and/or regional trends in such things as population growth and demographics, health status, health care costs, advances in technologies, etc.
- Collaborating with its public and private partners, members, Contractors, and other stakeholders.
- Building on its successes.

AHCCCS uses a participative and collaborative process to identify new clinical and nonclinical initiatives designed to improve quality of care, health outcomes, member satisfaction, and member well-being. AHCCCS ensures that the initiatives are aligned with its overall strategic goals and objectives related to quality, and with its quality improvement processes.

In selecting and initiating new quality improvement initiatives, AHCCCS:

- Identifies priority areas for improvement.
- Establishes realistic outcome-based performance measures.

- Identifies, collects, and assesses relevant data.
- Considers incentives for excellence and imposes sanctions for poor performance.
- Shares best practices with and provides technical assistance to Contractors.
- Includes relevant, associated requirements in its contracts.
- Regularly monitors and evaluates Contractor compliance and performance.
- Maintains an information system that supports initial and ongoing operations and review of AHCCCS's quality strategy.
- Conducts frequent evaluation of the initiatives' progress and results.

AHCCCS implements quality initiatives that are specific to one of its Medicaid managed care programs, as well as quality initiatives that cross all or more than one of its programs and Contractors. Examples of quality initiatives across its programs that AHCCCS had under way during the period covered by this report included, but were not limited to, the following:

- Implementing the Governor's e-Health Roadmap. AHCCCS applied for and was awarded a CMS Medicaid Transformation Grant. Under the grant, AHCCCS is designing and preparing to deploy a Statewide health information exchange (HIE) utility, an electronic health record (EHR) central repository, and a Web-based system to access and maintain the EHR.
- Continuing its participation in the "Arizona Health Query." Together with other major Arizona health care providers, AHCCCS is a partner in a health data system that aggregates and analyzes essential, comprehensive health information for Arizona residents that tracks individuals across systems over time.
- Continuing to enhance its data warehouse system to enable end users to quickly access AHCCCS data for a range of quality and medical management studies.
- Participating in the Center for Health Care Strategies (CHCS) grant that focuses on developing the Medicaid pay-for-performance program and a related CHCS grant focused on return on investment designed to evaluate the value of investing in pay for performance.
- Continuing its collaboration with the Arizona Department of Health Services (ADHS) to ensure effective administration and oversight of the federal Vaccines for Children (VFC) program and working with AHCCCS Contractors to ensure that providers ADHS placed on probation provide necessary vaccinations to members.
- Continuing to work collaboratively with the ADHS Office of Environmental Health (OEH) and AHCCCS Contractors to increase member testing for lead and identification of members with elevated blood levels of lead.
- Working with the ADHS Office of Nutrition on a Statewide program responsive to the Governor's call to action on childhood obesity. AHCCCS adopted the chronic care model for planning and developing a comprehensive approach to reduce or prevent childhood obesity.
- Collaborating with the Arizona Early Intervention Program (AzEIP), Arizona's IDEA Part C program, to facilitate early intervention services for children younger than 3 years of age who are enrolled with AHCCCS Contractors.
- Facilitating a collaborative work group focused on members who are seriously mentally ill and have medical complexities to allow the members to live in the community and not at a higher level of care.

AHCCCS Quality Initiatives Driving Improvement for the Acute Care and Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP) Contractors

Examples of AHCCCS's quality initiatives driving improvement for the Acute Care and DES/CMDP Contractors included, but are not limited to, the following:

- Analyzed historical trends in Contractor performance on AHCCCS-required measures and issued notices to cure or letters of concern, advising Contractors of the sanctions AHCCCS would impose if their performance did not meet AHCCCS's minimum performance standards. AHCCCS required the Contractors to develop CAPs to bring their performance up to the AHCCCS minimum standard, or if CAPs were already in place, to evaluate each activity under the CAPs to determine its effectiveness. In addition, Contractors had to identify to AHCCCS whether they were going to continue activities or implement new interventions to improve their performance.
- With Contractor input on AHCCCS's proposed methodology, continued its work in developing and implementing a new PIP focused on asthma management that will use HEDIS 2006 specifications for the baseline measurement and may include analyzing emergency room and hospital inpatient utilization to evaluate the effectiveness of the PIP.
- Based on AHCCCS assessments and other data, facilitated a collaborative effort between AHCCCS, Contractors, and other State and county organizations that targeted efforts to improve childhood immunization rates in one county through enhanced provider and community education.
- Hosted an Acute Care and DES/CMDP Contractor Administrators meeting that addressed quality-related topics including national and Arizona perspectives on electronic health records and health information exchange, notices to cure for performance measures, enteral feedings, notices of action policy and guide, and the CYE 2008 contracts.
- Calculated and reported Contractor performance for AHCCCS-required PIPs. AHCCCS required the Contractors to submit reports that included an analysis of the data and barriers to care/services, and the Contractors proposed new or revised interventions, if necessary.

5. Contractor Best and Emerging Practices

Best practices can be achieved by striving to incorporate evidence-based guidelines into operational structures, policies, and procedures. One method that AHCCCS has used to achieve best practices among Acute Care and DES/CMDP Contractors is to ensure that the State's organizational assessment and structure standards are at least as stringent as those in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR 438.204 [g]). Further, the State's verification that Subpart D provisions of the BBA regulations are incorporated in Medicaid contract provisions (42 CFR 438.204 [a]) has included standards that directly pertain to the following areas:

- Access to care (availability and adequate capacity of services, coordination and continuity of care, and coverage and authorization of services)
- Structure and operations (provider selection, confidentiality, and grievance system)
- Quality measurement and improvement provisions (practice guidelines, quality assessment, performance improvement, and health information systems)

Of particular note is the sharing of best practices among AHCCCS and its Contractors. AHCCCS provides opportunities and forums for regularly sharing best practices with, and providing technical assistance to, its Acute Care and DES/CMDP Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful quality improvement strategies and interventions during AHCCCS Contractor Quality Management meetings. AHCCCS's use of these meetings as a forum for addressing performance improvement opportunities and initiatives is in itself, a best practice.

AHCCCS's policies reward quality of care, member safety, and member satisfaction outcomes; support evidence-based best practices in disease management and preventive health; provide feedback on quality and outcomes to Contractors and providers; and provide for strategic, periodic monitoring of a wide variety of processes and outcomes. As part of its five-year goals, AHCCCS has adopted the following tenets:

- Enhance current performance measures and performance improvement projects and best practices activities by creating a comprehensive quality-of-care assessment and improvement plan across AHCCCS Medicaid programs that serves as a roadmap for driving improvement of member-centered outcomes
- Continue using nationally recognized protocols, standards of care, and benchmarks
- Continue using a system of rewards for providers, in collaboration with its Contractors, based on clinical best practices and outcomes
- Develop collaborative strategies and initiatives with State agencies and external partners, including the following:
  - Strategic partnerships to improve access to health care services and affordable health care coverage
  - Collaboration with Contractors and providers on best practices in disease prevention and health maintenance

The results of AHCCCS's leadership in developing and promoting systems and cultures of best practices across Contractors can be seen through one outcome of the Provider Reporting to ASIIS PIP. AHCCCS facilitated a Contractor-wide collaborative to identify and analyze the root causes of failure to report to ASIIS at the desired levels. Interventions were developed and implemented by all Contractors to use in educating providers on reporting. Effective interventions have lead to a substantive improvement in the proportion of providers reporting immunization data to the State registry. After the first remeasurement, Acute Care Contractors have shown the effectiveness of the PIP process in increasing the timeliness and completeness of reporting the State's administrative immunization data. A review of the various interventions employed by Acute Care and CMDP Contractors identified two underlying, emerging practices: enhanced provider communication/education and improved monitoring.

Key interventions implemented as a result of this PIP included the following best practices:

- Increased provider education through multiple media (mail, fax, phone calls, and lunch meetings) to increase awareness of State reporting requirements and procedures, as well as feedback on the timeliness and quality of reporting following record review.
- Implemented enhanced monitoring of provider compliance with timeliness and completeness of reporting. Noncompliant provider offices were given personalized feedback to assist with general improvement.
- Conducted provider surveys to identify additional barriers to reporting.

In addition to improvements related to CYE 2007 PIPs, some emerging best practices were identified from those Contractors where significant improvement was demonstrated for the performance measures. A review of the Contractors' strategies showed a variety of approaches that increased communication with both providers and members. Strategies employed by Acute Care and DES/CMDP Contractors included, but were not limited to, the following:

- Implemented phone call reminder systems to remind members of upcoming appointments or the need for appointments, and to reschedule when appointments are missed
- Enhanced educational outreach that focused on promoting the use of self-referrals and available transportation services
- Improved collaboration with provider offices to assist in member outreach
- Provided preventive services (e.g., dental screenings) at health fairs

Overall, AHCCCS and the Contractors are succeeding in instilling a culture of quality improvement with results that confirm the effectiveness of the program. Using extensive monitoring and aggressive CAPs, the reported quality indicator rates have somewhat improved. Through the organizational assessment and structure standards review, the performance measures, and the PIPs, AHCCCS and the Acute Care and DES/CMDP Contractors are actively working toward improving timely access to quality care for their Medicaid members.

6. Organizational Assessment and Structure Performance

State Medicaid and licensing agencies, private accreditation organizations, and the federal Medicare program all recognize that having standards is only the first step in promoting safe, accessible, timely, and quality services. The second step is ensuring compliance with the standards.

According to 42 CFR 438.358, which describes activities related to external quality reviews, the state Medicaid agency, its agent that is not an MCO or PIHP, or an EQRO must conduct a review within a three-year period to determine MCOs' and PIHPs' compliance with state standards. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described at 42 CFR 438 that address requirements related to access, structure and operations, and measurement and improvement.

AHCCCS has extensive experience preparing for, conducting, and reporting findings from its reviews of Contractors' performance in complying with federal and State requirements. As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the BBA mandatory compliance review activity. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1-5), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its compliance review activities to prepare this 2006–2007 annual report.

Conducting the Review

The 2006–2007 OFR began a new three-year cycle of AHCCCS OFRs. AHCCCS conducted an extensive review of the Contractors' performance to assess their compliance with federal and State law, rules, and regulations, and the AHCCCS contract. AHCCCS assessed the Acute Care and the DES/CMDP Contractors' compliance with standards in 13 performance areas:

- Behavioral Health
- Claims Systems
- Cultural Competency/Limited English Proficiency
- Delivery Systems
- Encounters
- General Administration/Corporate Compliance
- Authorization and Denial/Grievance Systems
- Maternal and Child Health
- Medical Management
- Member Services
- Quality Management
- Reinsurance
- Third Party Liability

Objectives for Conducting the Review

AHCCCS's objectives for conducting the OFR were to:

- Determine if the Contractors satisfactorily met AHCCCS's requirements as specified in their contract, AHCCCS policies, the Arizona Administrative Code (AAC), and Medicaid managed care regulations (42 CFR).
- Increase AHCCCS's knowledge of the Contractors' operational and financial procedures.
- Provide technical assistance and identify areas where Contractors can improve and areas of noteworthy performance and accomplishments.
- Review the Contractors' progress in implementing recommendations AHCCCS made during prior OFRs.
- Determine if the Contractors complied with their own policies and evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by CMS in accordance with AHCCCS's 1115 waiver.
- Provide information to HSAG as AHCCCS's EQRO for its use in preparing this report as described in 42 CFR §438.364.

HSAG designed a summary tool to:

- Organize and represent the information AHCCCS presented in the nine Acute Care and DES/CMDP individual Contractor reports that documented each Contractor's performance in complying with the operational and financial standards.
- Facilitate a comparison of the Contractors' performance.

The summary tool focused on the objectives of HSAG's analysis, which were to:

- Determine each Contractor's compliance with standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
- Provide data from the review of each Contractor's compliance with the standards that would allow HSAG to draw conclusions as to the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide, across the Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and across Contractors.

Methodology for Conducting the Review

While AHCCCS reviews the operational and financial performance of the Contractors throughout the year, it also conducts an annual, formal operational and financial review (OFR) of each Contractor. AHCCCS follows a CMS-approved process to conduct the OFRs that is also consistent with CMS' protocol for EQROs that conduct the reviews—i.e., the February 11, 2003, Final Protocol (Version 1.0), *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Contractors (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR, Parts 400, 430, et. al.

Beginning a new three-year cycle of OFRs, AHCCCS conducted an extensive review of Contractor performance in meeting standards. AHCCCS provided the Contractors with: (1) a detailed description of the contract requirements and expectations for each of the standards that AHCCCS would review and (2) a list of documents and information that was to be available to AHCCCS for its review during the OFR on-site review process.

AHCCCS's methodology was consistent across all Contractors and included the following:

- Desk review activities that AHCCCS conducted prior to its on-site review to minimize the time needed on-site and to begin its assessment of the Contractors' performance by reviewing documents Contractors were required to submit to AHCCCS.
- On-site review activities that included AHCCCS reviewing additional Contractor documentation and conducting interviews with key Contractor administrative and program staff. Reviews generally required three to five days, depending on the extent of the review and the location of the Contractor.
- Activities AHCCCS conducted following the on-site review, including:
  - Documenting and compiling the results of its reviews, preparing the draft reports of findings, and issuing the draft reports to the Contractors for their review and comment. In the report, each standard and substandard was individually listed with the applicable performance designation based on AHCCCS's review findings and assessment of the degree to which the Contractor was in compliance with the standards. *Full Compliance* was 90 to 100 percent compliant, *Substantial Compliance* was 75 to 89 percent compliant, *Partial Compliance* was 50 to 74 percent compliant, and *Non-Compliance* was 0 to 49 percent compliant. If a standard was not applicable to a Contractor, AHCCCS noted this using an *N/A* designation. The reports sent to the Contractors also included, when applicable, any AHCCCS recommendations, which were stated as:
    a. *The Contractor must*….This statement indicates a critical noncompliant area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
    b. *The Contractor should*….This statement indicates a noncompliant area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the Contractor.
    c. *The Contractor should consider*….This statement is a suggestion by the review team to improve the operations of the Contractor but is not directly related to contract compliance.
  - Reviewing and responding to any Contractor challenges to AHCCCS's draft report findings and, as applicable based on its review of the challenges, revising the draft reports.
  - Issuing the final Contractor reports describing the findings, scores, and, as applicable, required Contractor CAPs for each standard AHCCCS reviewed.

AHCCCS's review team members included employees of the Division of Health Care Management (DHCM) Reinsurance, Operations, Finance, Data Analysis and Research, Medical Management and Clinical Quality Management units, the Office of Program Integrity, the Office of Administrative Legal Services, and the Division of Business and Finance Third Party Liability unit.

AHCCCS's review activities conform to the CMS requirement to assess each Contractor on the extent to which it addressed recommendations for quality improvement AHCCCS made as a result of its findings from the previous year's review. Fundamental to this process, AHCCCS requires its Contractors to propose formal CAPs—and have them accepted by AHCCCS—for deficiencies in the Contractor's performance that AHCCCS identified as part of its ongoing monitoring and/or formal annual OFR processes.

From its review of the Contractors' CAPs and associated documentation, AHCCCS determines if:

- The activities and interventions specified in the CAPs could reasonably be anticipated to correct the deficiencies AHCCCS identified during the OFR (or other monitoring activity) and bring the Contractor back into compliance with the applicable AHCCCS standards.
- The documentation demonstrates that the Contractor had implemented the required action(s) and is now in compliance with one or more of the standards requiring a CAP.
- Additional or revised CAPs or documentation are still required from the Contractor for one or more standards and the CAP process remains open and continuing.

AHCCCS follows up on each Contractor's implementation of the CAPs and related outcomes during its ongoing monitoring and oversight activities as well as during future OFRs. These activities determine whether the corrective actions were effective in bringing the Contractor back into compliance with AHCCCS requirements.

Following a preliminary review of AHCCCS's documentation of its OFR findings, and to ensure that HSAG was using complete and accurate information in preparing the annual report, HSAG developed and provided to AHCCCS a list of questions or requests for clarification related to AHCCCS's documentation and data. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the accuracy and completeness of the data and information that HSAG would use to prepare this 2006–2007 annual report.

Using the verified results AHCCCS obtained from conducting the OFRs, HSAG organized and aggregated the performance data and the required CAPs for each Contractor and across the Contractors. HSAG then analyzed the data by performance area (e.g., Quality Management, Behavioral Health, and Claims Systems) and by each of the individual standards within an area.

Based on its analysis, HSAG drew conclusions about the quality and timeliness of, and access to, care and services provided by each Contractor and statewide across Contractors. HSAG identified data-driven Contractor performance strengths and, where applicable, opportunities for improvement. When HSAG identified opportunities for improvement, it also provided recommendations to improve the quality and timeliness of, and access to, the care and services Contractors provide to AHCCCS members.

Contractor-Specific Results

AHCCCS conducted an extensive OFR for eight Acute Care Contractors and for DES/CMDP. AHCCCS reviewed Contractors' performance on 148 to 157 compliance standards, depending upon the Contractor.[6-1] The percentage of these standards with performance in full compliance with requirements ranged from 66 to 90 percent across the Contractors. Separate results for each of the Contractors are presented next, followed by comparative results across Contractors.

[6-1] Differences in the number of standards reviewed were due to some standards being not applicable to specific Contractors.

Arizona Physicians IPA, Inc. (APIPA)

APIPA serves eligible, enrolled members in all Geographic Service Areas (GSAs) except GSA 8 (Pinal and Gila counties) and has contracted with AHCCCS since 1982. At the time of this review, the Contractor had approximately 270,930 members.

Findings

Figure 6-1 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-1—Categorized Levels of Compliance With Technical Standards for APIPA[6-2]

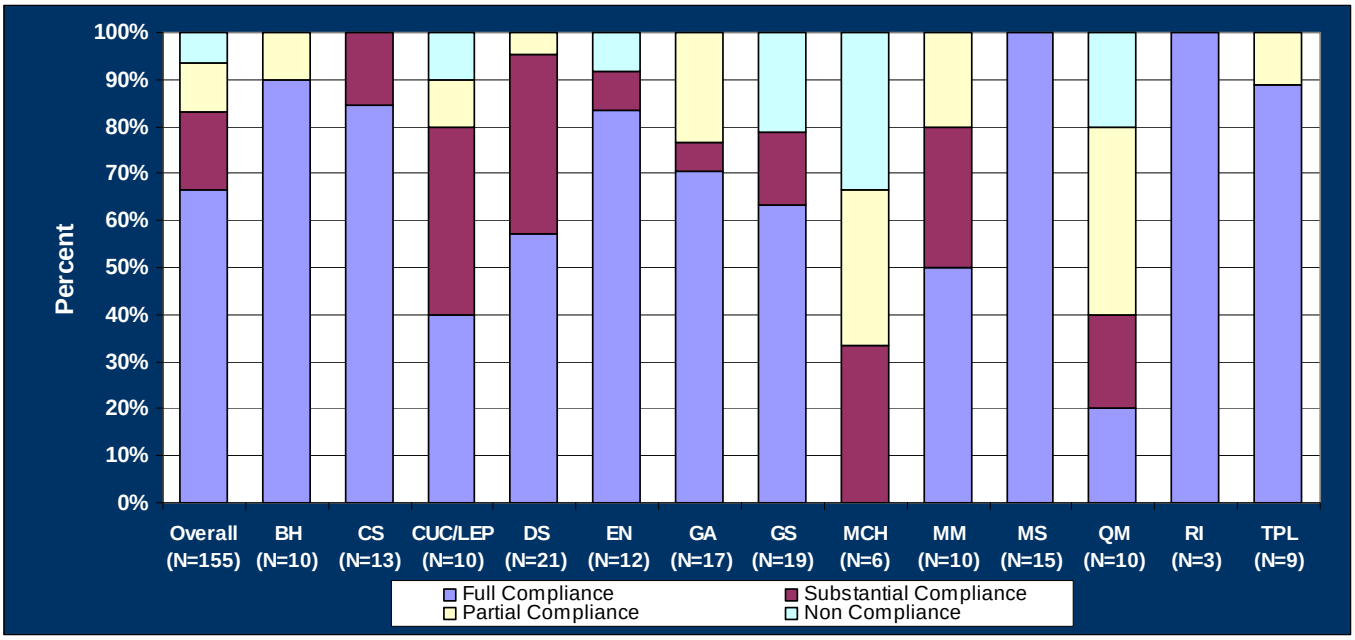


Figure 6-1 shows that APIPA was in full compliance with 66 percent of the 155 reviewed standards (left-most bar), with considerable variation in performance across the categories. Moreover, the percentage of each category that was in full compliance covers the maximum possible range, from 0 percent (Maternal/Child Health) to 100 percent (Member Services and Reinsurance). In addition to the two categories in full compliance with 100 percent of the reviewed standards, the Behavioral Health, Claim Systems, and Third Party Liability categories were assessed as having at least 85 percent of the reviewed standards in full compliance. Following the Maternal/Child Health category (0 percent in full compliance), the Quality Management, Cultural Competency/Limited English Proficiency, Medical Management, Delivery System, and Authorization and Denial/Grievance

[6-2] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

System categories represented areas with the next-greatest opportunities for improvement. Less than two-thirds of the standards in these categories were assessed as in full compliance.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Claim Systems category for APIPA. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-1 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-1—Corrective Action Plans By Category *for* APIPA

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	1	2%	10	10%
Claim Systems	3	6%	13	23%
Cultural Competency/Limited English Proficiency	6	11%	10	60%
Delivery System	9	17%	21	43%
Encounters	2	4%	12	17%
General Administration/Corporate Compliance	5	9%	17	29%
Authorization and Denial/Grievance System	7	13%	19	37%
Maternal/Child Health	6	11%	6	100%
Medical Management	5	9%	10	50%
Member Services	0	0%	15	0%
Quality Management	8	15%	10	80%
Reinsurance	0	0%	3	0%
Third Party Liability	1	2%	9	11%
Overall	**53**	**99%**	**155**	**34%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-1 shows that 17 percent (9 out of 53) of the required CAPs were within the Delivery System category, followed by the Quality Management (15 percent) and Authorization and Denial/Grievance System (13 percent) categories. Notably, two categories did not require any CAPs (Member Services and Reinsurance) and only one CAP each was required for the Behavioral Health and Third Party Liability categories. Based on the proportion of standards requiring a CAP within a category, the Maternal/Child Health category exhibited the greatest opportunity for improvement since 100 percent of the reviewed standards required a CAP. This category was followed by the Quality Management, Cultural Competency/Limited English Proficiency, and Medical Management, for which at least 50 percent of the reviewed standards required CAPs. Overall, 53 of the 155 reviewed standards (34 percent) required a CAP in CYE 2007.

Table 6-2 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-2—Two-Year CAP Overview *for* APIPA

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	4	29%	13	3	23%
Delivery System	11	1	9%	21	9	43%
Authorization and Denial/Grievance System	22	12	55%	19	7	37%
Maternal/Child Health	7	4	57%	6	6	100%
Medical Management	5	2	40%	10	5	50%
Quality Management	3	3	100%	10	8	80%
Reinsurance	4	3	75%	3	0	0%
Third Party Liability	10	2	20%	9	1	11%
Overall	**76**	**31**	**41%**	**91**	**39**	**43%**

Overall, Table 6-2 indicates that APIPA's performance in CYE 2007 (43 percent) remained relatively unchanged from CYE 2006 (41 percent). However, when evaluated by individual category, the findings suggest some improvement based on the decrease in the percentage of CAPs required for the Authorization and Denial/Grievance System (a 33 percent decrease), Reinsurance (a 100 percent decrease), and Third Party Liability (a 45 percent decrease). Additionally, the Claim Systems and Quality Management categories showed improvement, although somewhat smaller, through a reduction in the percentage of required CAPs (21 percent and 20 percent, respectively). These improvements, however, are tempered by the opportunities for improvement noted in the proportional increase in required CAPs for the Delivery System (378 percent increase), Maternal/Child Health (75 percent increase), and Medical Management (25 percent increase) categories.

Strengths

All of the reviewed standards within the Member Services and Reinsurance categories were assessed to be in full compliance with AHCCCS's technical standards. As such, these areas were identified as a recognized strength for APIPA. Additional strengths were also identified within the Authorization and Denial/Grievance System, Reinsurance, and Third Party Liability categories based on the relative improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from APIPA's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights three key themes that underlie several opportunities for improvement across multiple categories. These themes include effectively communicating with members and providers, ensuring complete and accurate documentation of policies and procedures, and enhancing monitoring of APIPA's programs. For example, AHCCCS recommended that APIPA enhance current notifications and letters for informing members and providers of its cultural competency program and of their rights regarding authorizations and the grievance process (Cultural Competency/Limited English Proficiency and Authorization and Denial/Grievance Systems). AHCCCS also recommended that APIPA strengthen the materials outlining the appropriate use of the Parents' Evaluation of Developmental Status (PEDS) tool and coordination of care for the Sixth Omnibus Budget Reconciliation Act (SOBRA) members (Maternal/Child Health). AHCCCS also recommended refinement of policies regarding new technologies and concurrent review (Medical Management) and notification letters regarding quality-of-care and abuse/complaint letters to members, providers, and agencies (Quality Management). These recommendations highlight the need for APIPA to evaluate its current policymaking processes and ensure that all policies and letters address AHCCCS requirements. Additionally, APIPA should ensure that all documents are written in commonly understood language for both members and providers. Establishing a strategy for the development of comprehensive, clear, and concise policies in all operational areas will not only improve APIPA's compliance with AHCCCS's standards, but also lead to more efficient operations.

AHCCCS also recommended that APIPA work to improve its monitoring of internal activities such as forwarding complaints to the Quality Management committee (Quality Management) and interrater reliability (Medical Management), interpreter services (Cultural Competency/Limited English Proficiency), timeliness of authorization decisions and notifications (Authorization and Denial/Grievance Systems), and staffing and provider network levels (Delivery Systems). Additionally, organizationwide deficiencies in monitoring member and provider utilization and quality programs were also noted in several areas (Cultural Competency/Limited English Proficiency, Quality Management, Medical Management, and Maternal/Child Health). Together, these recommendations highlight the importance of establishing comprehensive monitoring across all operational areas. It is strongly recommended that APIPA evaluate its current committee structures and accountabilities, monitoring activities and their frequency, and quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for those areas with the greatest opportunity for improvement: Cultural Competency/Limited English Proficiency, Delivery System, Authorization and Denial/Grievance System, Maternal/Child Health, Medical Management, and Quality Management.

- **Cultural Competency/Limited English Proficiency**: Overall, 60 percent (or 6 out of 10) standards reviewed in this category required a CAP. The six CAPs highlighted opportunities for improvement in APIPA's internal processes for ensuring multilingual staff qualifications and the cultural competency of employees, monitoring of member requests for alternative language

materials and use of interpretation services, and communicating more effectively the availability of translation services in a variety of languages and formats. In general, only one of the standards was found to be in noncompliance; the remaining CAPs were related to standards for which APIPA had at least partially addressed AHCCCS requirements. This finding highlighted a general lack of cohesion and responsibility in the management and implementation of APIPA's Cultural Competency Program. It is recommended that the Contractor form an internal work group to conduct a comprehensive assessment of the organizational and functional structure of its Cultural Competency Program. The focus of this work group should address multiple areas. First, it should evaluate whether there are adequate processes in place to ensure coordination of cultural competency-related plans and activities across the organization and provider network. The work group should also take steps to formalize hiring and management of multilingual staff to ensure all AHCCCS requirements for staff are met. Further, the work group should evaluate current policies and procedures as well as member and provider materials to ensure the information on the availability of translation services is readily available and that providers are aware of the cultural competency requirements. Additionally, the work group should identify appropriate measures and reporting for ongoing monitoring of the effectiveness of the Cultural Competency Program, including the identification of an appropriate committee for reviewing results. Based on the findings of this work group, APIPA should strengthen its approach and activities with regard to providing culturally competent services to its members.

- **Delivery System**: Of the 21 standards reviewed in this category, 9 standards (43 percent) required a CAP in CYE 2007. However, none of these standards was found to be in noncompliance. All standards requiring a CAP were assessed as in partial or substantial compliance. In general, the nine CAPs highlight the following three underlying opportunities for improvement:
  - Developing more effective systems for compiling and tracking data to ensure that AHCCCS's appointment standards are being met
  - Enhancing policies and procedures for training staff and providers on the AHCCCS line of business and appointment standards
  - Developing effective strategies for evaluating appropriate provider services staffing levels

  To address these opportunities for improvement, it is recommended that APIPA further develop current processes surrounding the monitoring of provider appointment availability. In most cases, APIPA has a mechanism in place to monitor provider appointments; however, no process was identified for measuring appointment availability against AHCCCS standards. APIPA should explore the capabilities of its current tracking systems to identify how current data can be used and reported to address AHCCCS monitoring requirements. The Contractor should also conduct an in-depth review of its policies and procedures related to staff and provider education.

  This review should identify areas where the Contractor can enhance the consistency with which the Contractor ensures providers are complying with appointment standards, and ensure that internal staff remains up to date on the AHCCCS line of business. Finally, the Contractor should revisit its methodology for evaluating the appropriate number of provider services representatives needed and include provider feedback regarding their responsiveness and accessibility.
- **Authorization and Denial/Grievance System**: Overall, 37 percent (or 7 out of 19) of the reviewed standards required a CAP in CYE 2007. These seven CAPs highlight opportunities for improvement in two underlying areas:

- Implementing an effective means of monitoring compliance with timeliness standards associated with notifying members and providers of the status of service authorization requests
- Revising existing notice of action letters to enhance explanations of the service authorization process and status, written in easily understood language.

To address the underlying issues identified above, it is recommended that APIPA invest resources in developing a tracking and reporting database to be integrated with its current authorization processes. Using currently available office software, APIPA should design and implement an application that allows multiple staff to collect and enter information about the authorization requests received and adjudicated. This system could then be used to generate automated reports and populate monitoring dashboards to highlight current trends and adherence to AHCCCS and BBA standards. Additionally, APIPA's compliance committee should review its current authorization policies and notices of action and cross-reference them with AHCCCS requirements. When deficiencies are noted, policies and letters should be revised and aligned with AHCCCS requirements. Further, the language and format of the letters should be reviewed and revised as applicable to increase the readability of the notices. Finally, once notice of action letter templates have been updated, they can be integrated into an authorization tracking and reporting database such that letters are automatically generated according to authorization guidelines.

- **Maternal/Child Health:** This entire category represents an opportunity for improvement for APIPA as 100 percent of the six reviewed standards required a CAP in CYE 2007. In general, AHCCCS's review indicated that while APIPA had an effective case management process in place to ensure that high-risk pregnant members received needed care and services, the Contractor did not have an effective system to monitor maternity program outreach activities and members' utilization of prenatal and postpartum services. Both of these areas represent quality issues. Additionally, several CAPs were related to APIPA's coordination with the Arizona Early Intervention Program (AzEIP) and use of the PEDS tool. Of note is the continuation of a CAP related to APIPA's process of having providers refer members to AzEIP instead of the Contractor. Finally, one CAP dealt with the referral of SOBRA women to appropriate family planning services once eligibility was terminated. These CAPs underscore the importance of comprehensive monitoring designed to provide the Contractor with ongoing information related to its maternal and child health programs. It is recommended that the Contractor convene a time-limited committee to design and implement a maternal/child health monitoring program. This committee should include cross-departmental staff familiar with other APIPA monitoring programs and data sources available for monitoring utilization. Once established, the committee should cross-reference AHCCCS requirements with current programs and data sources and recommend effective methods and measures for tracking utilization and performance in maternal/child health programs. At a minimum, efforts should be focused on prenatal and postpartum visits and maternity outreach programs. Additionally, APIPA should revise its policies, strengthen its coordination with AzEIP, and strengthen implementation of the PEDS tool, including appropriate and accurate education to providers.
- **Medical Management:** Overall, 50 percent (or 5 out of 10) of the reviewed standards in this category required a CAP in CYE 2007. Four of the five required CAPs highlighted opportunities for improvement in two underlying areas:

- APIPA's application of information collected from members (e.g., Health Risk Assessment and outcomes measures) to the management of special needs and at-risk members and the monitoring of its disease management programs.
- The incomplete documentation of policies regarding concurrent review and the evaluation of new technologies. Additionally, one CAP highlighted the need for APIPA to revise its interrater reliability policies and procedures to include an evaluation of staff's application of standardized criteria in decision making.

To address these CAPs, it is recommended that APIPA establish a cross-functional team to evaluate the processes and accountabilities needed to integrate findings from the Health Risk Assessment into APIPA's local disease management and case management programs. While reports are currently available, the Contractor should identify methods for integrating information electronically to facilitate coordination of care. Additionally, this team should evaluate current reports and sources of data related to the outcomes of APIPA's current disease management programs. The findings from this review should be used to generate a strategy for incorporating this information into the ongoing management and quality improvement activities. The team should also outline procedures that ensure the results of these activities are regularly reviewed and the changes in program implementation are made and documented as appropriate. Additionally, it is recommended that APIPA establish an internal work group to review current policies and procedures and ensure that its documents meet AHCCCS's requirements. This process can be established by cross-referencing policies with AHCCCS-specific contract language. In particular, the Contractor should ensure that details regarding the timelines and criteria for concurrent review decisions are clearly outlined in policies, as well information regarding the timelines and sources for evaluating new technologies. Moreover, APIPA should establish an annual process for reviewing all policies to ensure future compliance with AHCCCS standards.

- **Quality Management:** Of the 10 standards reviewed in this category, 8 standards (80 percent) required a CAP in CYE 2007. In general, the eight CAPs highlighted three underlying opportunities for improvement:
  - Enhancing communication with members, providers, and agencies (i.e., quality-of-care concerns, allegations of abuse and complaints, and member rights)
  - Revising key policies to include all AHCCCS requirements (i.e., credentialing and delegation)
  - Implementing strategies to incorporate data collected from monitoring activities into the quality improvement process (i.e., performance measures and quality management [QM] interventions).

  Additionally, one CAP was related to the number of unfilled key quality management staff positions. Vacancies in these positions will continue to affect APIPA's ability to document and resolve quality concerns in a timely manner. As noted in the other categories, it is recommended that APIPA conduct an internal audit of its current policies and procedures and cross-reference them with AHCCCS's requirements. Once areas with discrepancies and/or areas that need clarification are identified, APIPA should take the necessary steps to revise its documents to bring them into alignment with AHCCCS standards. The Contractor should also task a standing committee with the responsibility for annually reviewing the content and form of all policies to ensure continued compliance. Additionally, the Contractor would also benefit from developing and operationalizing a systemwide focus on reaching out to, informing, and seeking feedback

from its members and providers. Finally, as noted in the previous categories, it is recommended that APIPA establish a cross-functional team to develop a comprehensive strategy for integrating the results from performance measure CAPs and other quality improvement activities into the quality management process. Specifically, APIPA should develop an organizational approach that integrates information from all steps and activities into its QM process—from identification of need, through the implementation of interventions, to the evaluation of effectiveness—to provide a fully recursive model of feedback and continuous improvement.

Summary

In general, APIPA's compliance with AHCCCS's operational and financial standards remained unchanged in CYE 2007. Although some individual categories (i.e., Behavioral Health, Claim Systems, Member Services, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, the remaining categories had considerable opportunities for improvement. Notably, all the standards within the Member Services and Reinsurance categories were assessed to be in full compliance and are recognized strengths for APIPA.

Care1st Health Plan (Care1st)

Care1st serves eligible, enrolled members in GSA 12 (Maricopa County) and has contracted with AHCCCS since 2003. At the time of this review, the Contractor had approximately 27,900 members.

Findings

Figure 6-2 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-2—Categorized Levels of Compliance With Technical Standards for Care1st[6-3]

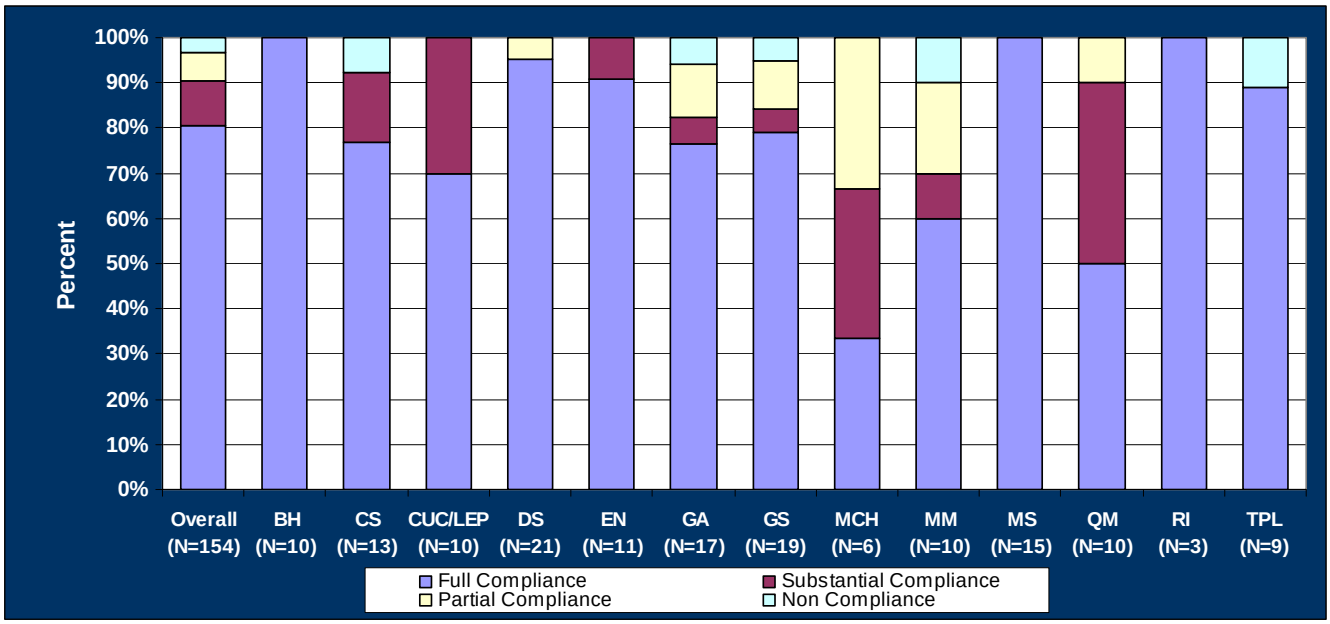


Figure 6-2 shows that Care1st was in full compliance with 81 percent of the 154 reviewed standards (left-most bar), with moderate variation in performance across the categories. The percentage of each category in full compliance ranged from 33 percent (Maternal/Child Health) to 100 percent (Behavioral Health, Member Services, and Reinsurance). In addition to the three categories in full compliance with 100 percent of the review standards, the Delivery System, Encounters, and Third Party Liability categories were assessed with at least 85 percent of the reviewed standards in full compliance. Following the Maternal/Child Health category (33 percent in full compliance), the

[6-3] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability

Quality Management and Medical Management categories represented areas with the next-greatest opportunities for improvements (50 percent and 60 percent, respectively, in full compliance).

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Claim Systems and Medical Management categories for Care1st. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-3 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-3—Corrective Action Plans By Category *for* Care1st

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	0	0%	10	0%
Claim Systems	4	13%	13	31%
Cultural Competency/Limited English Proficiency	3	9%	10	30%
Delivery System	1	3%	21	5%
Encounters	1	3%	11	9%
General Administration/Corporate Compliance	4	13%	17	24%
Authorization and Denial/Grievance System	4	13%	19	21%
Maternal/Child Health	4	13%	6	67%
Medical Management	5	16%	10	50%
Member Services	0	0%	15	0%
Quality Management	5	16%	10	50%
Reinsurance	0	0%	3	0%
Third Party Liability	1	3%	9	11%
Overall	**32**	**102%**	**154**	**21%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-3 shows that the Medical Management and Quality Management categories had the largest proportion of CAPs in one category—each with 16 percent (5 out of 32) of the required CAPs—followed by the Claim Systems, General Administration/Corporate Compliance, Authorization and Denial/Grievance System, and Maternal/Child Health categories. Notably, three categories did not require any CAPs (Behavioral Health, Member Services, and Reinsurance) and only one CAP each was required for the Delivery System, Encounters, and Third Party Liability categories. Based on the proportion of standards requiring a CAP within a category, the Maternal/Child Health category exhibited the greatest opportunity for improvement since about two-thirds (67 percent) of the reviewed standards required a CAP. This category was followed by the Quality Management and Medical Management categories, for which half of the reviewed standards required CAPs. Overall, 32 of the 154 reviewed standards (21 percent) required a CAP in CYE 2007.

Table 6-4 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-4—Two-Year CAP Overview *for* Care1st

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	5	36%	13	4	31%
Delivery System	11	3	27%	21	1	5%
Authorization and Denial/Grievance System	22	7	32%	19	4	21%
Maternal/Child Health	7	3	43%	6	4	67%
Medical Management	5	3	60%	10	5	50%
Quality Management	3	1	33%	10	5	50%
Reinsurance	4	4	100%	3	0	0%
Third Party Liability	10	1	10%	9	1	11%
Overall	**76**	**27**	**36%**	**91**	**24**	**26%**

Overall, Table 6-4 indicates that Care1st's performance in CYE 2007 (26 percent) improved since CYE 2006 (36 percent), although the difference was not statistically significant (p=.201). When the results are evaluated by individual category, the improvement is further supported based on the relative decrease in the percentage of CAPs required for the Delivery System (81 percent decrease), Authorization and Denial/Grievance System (34 percent decrease), and Reinsurance (100 percent decrease) categories. Additionally, the Claim Systems and Medical Management categories showed improvement through a reduction in the percentage of required CAPs, although the decreases were somewhat smaller (14 percent and 17 percent, respectively). These improvements were tempered by the opportunities for improvement noted in the proportional increase in required CAPs for the Maternal/Child Health (56 percent increase) and Quality Management (52 percent increase) categories.

Strengths

All of the reviewed standards with the Behavioral Health, Member Services, and Reinsurance categories were assessed to be in full compliance with AHCCCS's technical standards. These areas were identified as a recognized strength for Care1st. Additional strengths were also identified within the Delivery System category based on the relative improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from Care1st's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: ensuring complete and accurate documentation of policies and procedures in compliance with AHCCCS standards and communicating these procedures to members and providers, and enhancing monitoring of Care1st's programs and performance results. For example, AHCCCS recommended that Care1st enhance its claims system and compliance program manuals to reflect required contract language and to include detailed review methodologies (Claim Systems and General Administration/Corporate Compliance), as well as the need to modify existing policies to include omitted AHCCCS language or clarifications (General Administration/Corporate Compliance, Delivery System, Maternal/Child Health, and Medical Management). AHCCCS also recommended several opportunities for Care1st to improve its communication with members and providers (Quality Management, Medical Management), including revising and disseminating outreach materials (Maternal/Child Health). These recommendations highlight the need for Care1st to develop an organization wide approach to creating policies and procedures that align with AHCCCS's required standards. The Contractor should take steps to evaluate its current policymaking processes and ensure the completeness and accuracy of all policies. Additionally, Care1st should ensure that all documents are written in commonly understood language and, as appropriate, communicated to members and/or providers in a timely manner. By establishing a corporatewide strategy for developing comprehensive, clear, and concise policies across operational areas, Care1st will enhance its operations as well as resolve outstanding required CAPs.

AHCCCS also recommended that Care1st improve its monitoring of internal activities like the timeliness of authorization decisions and notifications (Authorization and Denial/Grievance System), the ratio of pended encounters (Encounters), and the cultural competency of staff (Cultural Competency/Limited English Proficiency). Additionally, organization-wide deficiencies in monitoring member and provider utilization and quality programs were also noted in several areas (Delivery System, Quality Management, Medical Management, and Maternal/Child Health). Together, these recommendations highlight the importance of establishing a comprehensive strategy for regularly monitoring performance across all operational areas. It is strongly recommended that Care1st evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Maternal/Child Health, Medical Management, and Quality Management.

- **Maternal/Child Health:** Overall, 67 percent of the standards reviewed in CYE 2007 (four out of six standards) required a CAP. This category exhibited the greatest opportunity for improvement for Care1st. In general, AHCCCS's review indicated that while Care1st had an effective case management process in place to ensure that members with high-risk pregnancies received needed care and services, the Contractor did not have an effective system to monitor maternity program outreach activities or provider compliance with notifying members of their family planning rights. Additionally, several CAPs were related to Care1st's coordination with AzEIP and

monitoring and evaluating the use of the PEDS tool. Finally, one CAP dealt with the quality of outreach materials that described the availability of family planning services, including the SOBRA Family Planning Extension Program.

To address these CAPs it is recommended that the Contractor convene a time-limited work group to design and implement a comprehensive maternal/child health monitoring program. Building upon existing programs that monitor ongoing prenatal and postpartum visits, the work group should identify and recommend effective methods and measures for tracking and evaluating the effectiveness of Care1st's maternity outreach program. Additionally, Care1st should use this work group to develop effective strategies for monitoring provider compliance with using the PEDS tool. By developing a comprehensive strategy for monitoring and oversight of the maternal/child health program, Care1st will generate increased information upon which continuous quality improvement can be established. It is also recommended that Care1st conduct a review of the content and quality of its member and provider outreach materials regarding the availability of family planning services. This review should identify areas where policies are incomplete (i.e., inclusion of male members, availability of low-cost services, etc.) and lead to revisions to the policies and member/provider outreach materials. Finally, Care1st should revise its policies to remove any references indicating Care1st's direct referrals to AzEIP. It is recommended that Care1st regularly crosswalk its policies with AHCCCS standards to ensure that they are in alignment with AHCCCS's expectations.

- **Medical Management:** Overall, 50 percent (5 out of 10 standards) of the reviewed standards in this category required a CAP in CYE 2007. Three of the five required CAPs highlighted deficiencies in the quality and completeness of current policies and procedures (i.e., provider profiling methodology, concurrent review timelines, and evaluation of new technologies) while the other CAPs outlined opportunities for improvement in communicating clinical practice guidelines to providers and ongoing monitoring of disease management programs. As noted with Maternal/Child Health, it is recommended that the Contractor conduct a review of its medical management policies and procedures. Specifically, each policy should be crosswalked to the associated AHCCCS standard to ensure all mandatory language and processes are clearly and concisely documented. In many cases, Care1st would benefit from making its current policies more detailed and comprehensive. Additionally, Care1st should develop and implement a process for disseminating clinical practice guidelines to providers. To ensure broad and effective communication, the Contractor should use a variety of mechanisms to communicate this information, including its Web site, list server, provider newsletters, etc. In addition, the guidelines should be reviewed annually, updated as needed, and resubmitted to contracted providers. Finally, Care1st should use the Medical Management Committee to develop a process for measuring the outcomes of its disease management programs to effectively integrate the collection of data directly into the committee responsible for evaluating interventions and making recommendations for change. If possible, the Contractor should automate its disease management reports to further assist in streamlining this process.
- **Quality Management:** Of the 10 standards reviewed in this category, 5 standards (50 percent) required a CAP in CYE 2007. In general, these five CAPs encompassed three underlying opportunities for improvement. These areas included: monitoring performance and tracking interventions related to required CAPs, performance measures, and PIPs; monitoring delegated providers; and strengthening processes for credentialing/recredentialing organizational providers.

  To address these opportunities for improvement, it is recommended that the Contractor establish and charge a cross-functional team with developing a comprehensive strategy for integrating the

results from performance measure CAPs and other quality improvement activities into its quality management process. Specifically, Care1st should develop an organizational approach that integrates information from various quality management activities (i.e., CAPs, performance measures, and PIPs) and applies this data to the continuous evaluation and implementation of interventions. This process would enable the Contractor to establish a comprehensive system of continuous quality improvement that builds upon the successes of earlier activities. Additionally, the Contractor should conduct a review of its policies and procedures that address credentialing and delegated entities and revise them as needed to ensure that complete policies are appropriately in place and in full compliance with AHCCCS standards. Care1st should also consider ensuring that it annually reviews and, as needed, revises its policies and procedures to ensure their continued conformance with contract requirements.

Summary

In general, Care1st's compliance with AHCCCS's operational and financial standards somewhat improved in CYE 2007, although the change was not statistically significant. Additionally, while some individual categories (i.e., Behavioral Health, Delivery System, Encounters, Member Services, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, the remaining categories had considerable opportunities for improvement. Notably, all the standards within the Behavioral Health, Member Services, and Reinsurance categories were assessed to be in full compliance and were recognized strengths for Care1st.

Health Choice Arizona (HCA)

HCA serves eligible, enrolled members in GSAs 4, 8, 10, and 12, which include the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, and Pinal. The Contractor has contracted with AHCCCS since 1990 and had approximately 110,350 members at the time of this review.

Findings

Figure 6-3 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-3—Categorized Levels of Compliance With Technical Standards for HCA[6-4]

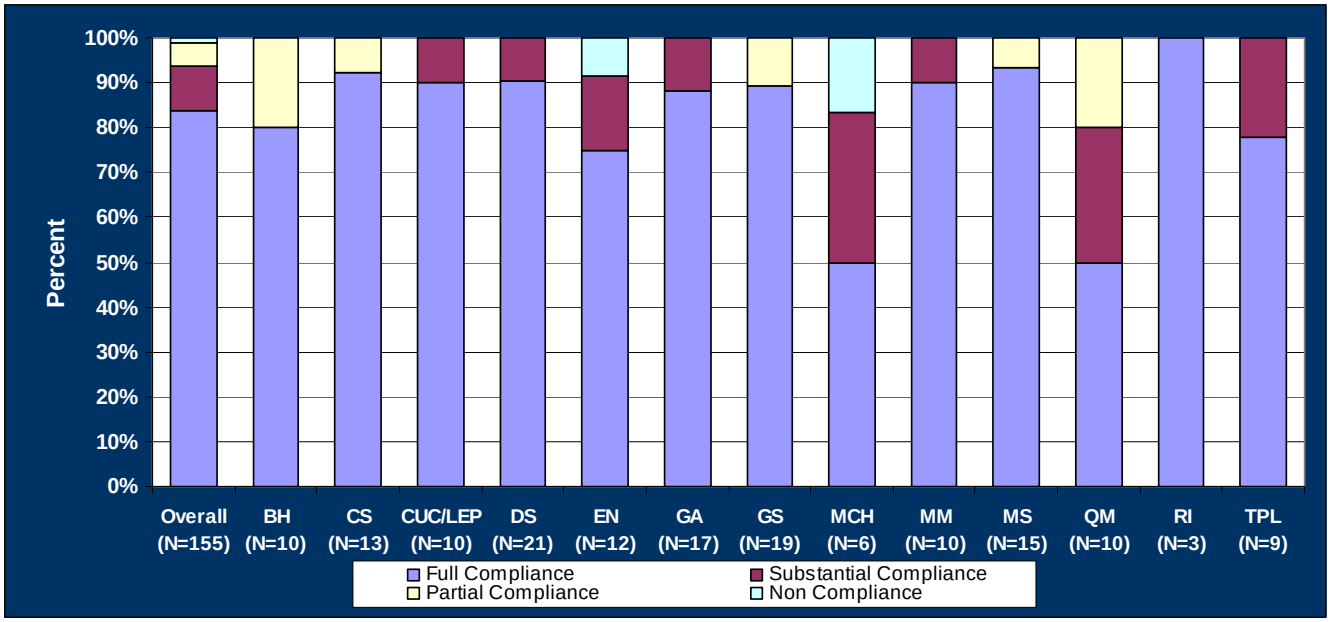


Figure 6-3 shows that HCA was in full compliance with 84 percent of the 155 reviewed standards (left-most bar), with some variation in performance across the individual categories. The percentage of each category that was in full compliance ranged from 50 percent (Maternal/Child Health and Quality Management) to 100 percent (Reinsurance). In addition to the one category in full compliance with 100 percent of the review standards, the Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Authorization and Denial/Grievance System, Medical Management, and Member

[6-4] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

Services categories were assessed with at least 85 percent of the reviewed standards in full compliance.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-5 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-5—Corrective Action Plans By Category *for* HCA

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	2	8%	10	20%
Claim Systems	1	4%	13	8%
Cultural Competency/Limited English Proficiency	1	4%	10	10%
Delivery System	2	8%	21	10%
Encounters	3	12%	12	25%
General Administration/Corporate Compliance	2	8%	17	12%
Authorization and Denial/Grievance System	2	8%	19	11%
Maternal/Child Health	3	12%	6	50%
Medical Management	1	4%	10	10%
Member Services	1	4%	15	7%
Quality Management	5	20%	10	50%
Reinsurance	0	0%	3	0%
Third Party Liability	2	8%	9	22%
Overall	**25**	**100%**	**155**	**16%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-5 shows that 20 percent (5 out of 25) of the required CAPs were within the Quality Management category. Notably, one category did not require any CAPs (Reinsurance) while only one CAP was required for the Claim Systems, Cultural Competency/Limited English Proficiency, Medical Management, and Member Services categories. Based on the proportion of standards requiring a CAP within a category, the Maternal/Child Health and Quality Management categories exhibited the greatest opportunity for improvement, with 50 percent of the reviewed standards requiring a CAP. These categories were followed by the Encounters category, for which 25 percent of the reviewed standards required CAPs. Overall, 25 of the 155 reviewed standards (16 percent) required a CAP in CYE 2007.

Table 6-6 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-6—2-Year CAP Overview *for* HCA						
	CYE 2006			CYE 2007		
Category	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	2	14%	13	1	8%
Delivery System	11	0	0%	21	2	10%
Authorization and Denial/Grievance System	22	10	45%	19	2	11%
Maternal/Child Health	7	0	0%	6	3	50%
Medical Management	5	1	20%	10	1	10%
Quality Management	3	0	0%	10	5	50%
Reinsurance	4	1	25%	3	0	0%
Third Party Liability	10	0	0%	9	2	22%
Total	**76**	**14**	**18%**	**91**	**16**	**18%**

Overall, Table 6-6 indicates that based on the overall percentage of required CAPs, HCA's performance in CYE 2007 (18 percent) remained unchanged from CYE 2006 (18 percent). However, when evaluated by individual category, the findings suggest some improvement based on the decrease in the percentage of CAPs required for the Claim Systems (a 43 percent decrease), Authorization and Denial/Grievance System (a 76 percent decrease), Medical Management (a 50 percent decrease), and Reinsurance (a 100 percent decrease) categories. These improvements, however, were tempered by the opportunities for improvement noted for four categories in which no CAPs were required in CYE 2006 but were required in CYE 2007—i.e., Delivery System (two CAPs), Maternal/Child Health (three CAPs), Quality Management (five CAPs), and Third Party Liability (two CAPs).

Strengths

All of the reviewed standards within the Reinsurance category were assessed to be in full compliance with AHCCCS's technical standards. This area was identified as a recognized strength for HCA. Additional strengths were also identified within the Claim Systems, Authorization and Denial/Grievance System, and Medical Management categories based on the large improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from HCA's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: ensuring complete and accurate documentation of policies and procedures in compliance with AHCCCS standards, and enhancing monitoring of HCA's programs and performance results.

For example, AHCCCS recommended that HCA revise its current policies and provider handbook to include information on expedited authorizations and peer-review investigations (Authorization and Denial/Grievance System and Quality Management), clarify the language and timelines related to the evaluation of new technology (Medical Management), and update policies related to member notification of provider terminations (Member Services). These recommendations highlight the need for HCA to develop an organizationwide approach to creating policies and procedures that align with AHCCCS's required standards. The Contractor should take steps to evaluate its current policymaking processes and ensure the completeness and accuracy of all policies. Additionally, HCA should ensure that procedures are developed to formalize the annual review and approval of policies to ensure future compliance.

AHCCCS also recommended that HCA improve member and provider monitoring activities related to member utilization of interpreter services (Cultural Competency/Limited English Proficiency), provider appointment availability and wait times compared to AHCCCS standards (Delivery System), compliance with encounter standards (Encounters), and tracking CAP implementation and interventions based on performance measure and PIP findings (Quality Management). Together, these recommendations highlight the importance of establishing a comprehensive strategy for monitoring performance results across all operational areas. It is recommended that HCA evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Maternal/Child Health and Quality Management.

- **Maternal Child Health:** Overall, 50 percent of reviewed standards (three out of six standards) in this category required a CAP. Each of the three CAPs addressed divergent types of issues. One of the CAPs addressed the Contractor's lack of documentation that it notifies providers that they should refer members to low/no-cost services in the event that members lose their eligibility, while another highlights the Contractor's failure to coordinate with AzEIP. The third CAP highlights the need for HCA to coordinate services for members identified as needing services based on the results of the PEDS evaluation. To address these opportunities for improvement, the Contractor should conduct a crosswalk comparison of its current policies and procedures with AHCCCS requirements to ensure that they are updated to reflect current standards. When deficiencies are noted, the Contractor should take appropriate steps to revise, re-approve, and disseminate the policies. Additionally, this review should encompass an examination of provider materials (i.e., manual/handbook, contracts, etc.) to verify that providers are fully informed about all contractual obligations. Finally, HCA should amend its process for coordinating with AzEIP and train internal staff on the appropriate process outlined by AHCCCS.
- **Quality Management:** Of the 10 standards reviewed in this category, 5 standards (50 percent) required a CAP in CYE 2007. These CAPs highlighted opportunities for improvement in HCA's monitoring of interventions and CAPs related to performance measures, PIPs, and member complaint/abuse issues, and the quality of several policies and procedures, including those related to provider peer review and member rights. It is recommended that HCA establish an internal work group to evaluate its current processes for collecting, reporting, and evaluating the progress of interventions and quality improvement activities based on performance measure and

PIP performance. The work group should focus on identifying effective mechanisms for integrating the evaluation results into a continuous quality improvement process. Moreover, these processes should be formalized and identified as a key function of HCA's Quality Management Committee. Guidance for this process can be found in the CMS protocol for conducting PIPs.[6-5] Additionally, the Contractor should conduct a review of its policies and procedures regarding provider peer review and a member's right to make decisions about his or her health care such that complete policies are in place and in full compliance with AHCCCS standards. HCA should also take proactive steps to ensure members and providers are made aware of these policies. Finally, the Contractor should take appropriate measures to formalize the annual review of policies and procedures to evaluate their continued compliance with AHCCCS standards. Implementing this process should include the involvement of senior management.

Summary

In general, HCA's overall compliance with AHCCCS's operational and financial standards remained relatively unchanged in CYE 2007. While some individual categories (i.e., Claim Systems, Cultural Competency/Limited English Proficiency, Delivery Systems, Medical Management, Member Services, and Reinsurance) exhibited a high percentage of standards in full compliance, several of the remaining categories had considerable opportunities for improvement (i.e., Maternal/Child Health and Quality Management). Notably, all the standards within the Reinsurance category were assessed to be in full compliance and were recognized as a strength for HCA.

[6-5] Conducting Performance Improvement Projects (Final Protocol Version 1.0, May 1, 2002, from the Centers for Medicare & Medicaid Services [CMS]).

Maricopa Health Plan

MHP serves eligible, enrolled members in GSA 12 (Maricopa County) and has contracted with AHCCCS since October 1, 1982. At the time of this review, the Contractor had approximately 33,800 members.

Findings

Figure 6-4 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-4—Categorized Levels of Compliance With Technical Standards for MHP[6-6]

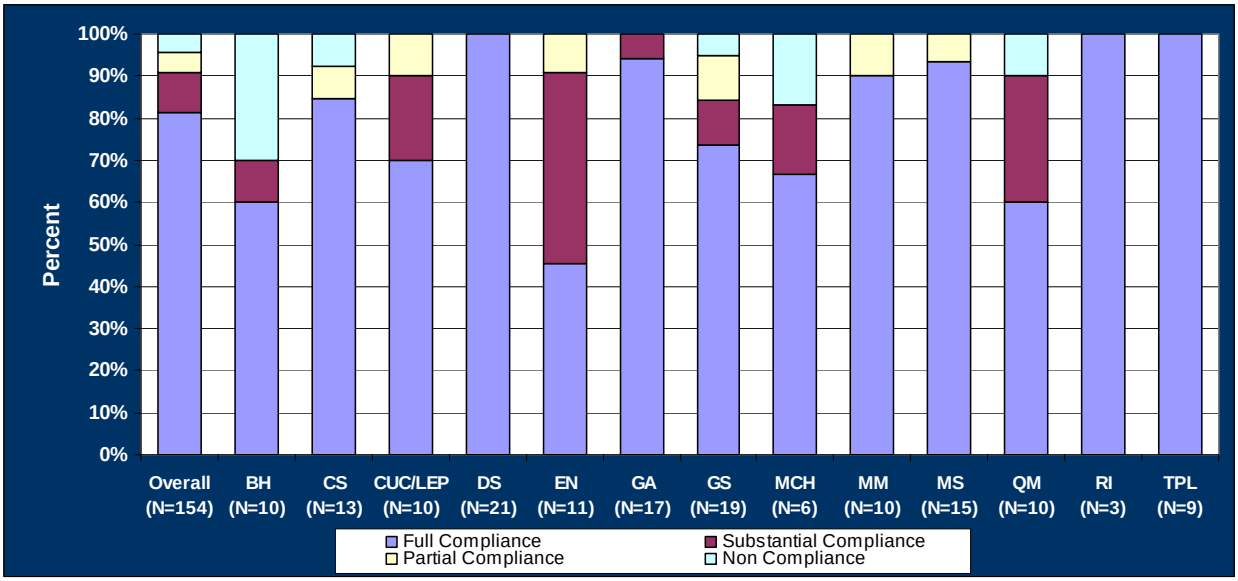


Figure 6-4 shows that MHP was in full compliance with 81 percent of the 154 reviewed standards (left-most bar), with moderate variation in performance across the individual categories. The percentage of each category that was in full compliance ranged from 45 percent (Encounters) to 100 percent (Delivery System, Reinsurance, and Third Party Liability). In addition to the three categories in full compliance with 100 percent of the reviewed standards, the Claim Systems, General Administration/Corporate Compliance, Medical Management, and Member Services categories were assessed with at least 85 percent of the reviewed standards in full compliance. Following the Encounters category (45 percent in full compliance), the Behavioral Health and

[6-6] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

Quality Management categories represented areas with the next-greatest opportunities for improvements (the two categories each had 60 percent in full compliance).

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Maternal/Child Health and Member Services categories for MHP. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-7 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-7—Corrective Action Plans By Category *for* MHP

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	4	13%	10	40%
Claim Systems	2	6%	13	15%
Cultural Competency/Limited English Proficiency	3	10%	10	30%
Delivery System	0	0%	21	0%
Encounters	6	19%	11	55%
General Administration/Corporate Compliance	1	3%	17	6%
Authorization and Denial/Grievance System	5	16%	19	26%
Maternal/Child Health	3	10%	6	50%
Medical Management	1	3%	10	10%
Member Services	2	6%	15	13%
Quality Management	4	13%	10	40%
Reinsurance	0	0%	3	0%
Third Party Liability	0	0%	9	0%
Overall	**31**	**99%**	**154**	**20%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-7 shows that the Encounters category had the largest proportion of CAPs, with 19 percent (6 out of 31) of the required CAPs, followed by the Authorization and Denial/Grievance System (16 percent), Behavioral Health (13 percent), and Quality Management (13 percent) categories. Notably, three categories did not require any CAPs (Delivery System, Reinsurance, and Third Party Liability) and only one CAP was required for the General Administration/Corporate Compliance and Medical Management categories. Based on the proportion of standards requiring a CAP within a category, the Encounters and Maternal/Child Health categories exhibited the greatest opportunities for improvement, with at least 50 percent of the reviewed standards requiring a CAP. These categories were followed by the Behavioral Health and Quality Management categories, for which 40 percent of the reviewed standards required CAPs. Overall, 31 of the 154 reviewed standards (20 percent) required a CAP in CYE 2007.

Table 6-8 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-8—Two-Year CAP Overview *for* MHP

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	4	29%	13	2	15%
Delivery System	11	0	0%	21	0	0%
Authorization and Denial/Grievance System	22	7	32%	19	5	26%
Maternal/Child Health	7	3	43%	6	3	50%
Medical Management	5	0	0%	10	1	10%
Quality Management	3	2	67%	10	4	40%
Reinsurance	4	2	50%	3	0	0%
Third Party Liability	10	3	30%	9	0	0%
Overall	**76**	**21**	**28%**	**91**	**15**	**16%**

Overall, Table 6-8 indicates that MHP's performance in CYE 2007 (16 percent) showed some improvement since CYE 2006 (28 percent), although the difference was not statistically significant (p=.081). When the results were evaluated by individual category, the improvement was further supported based on the relative decreases in the percentage of required CAPs for the Claim Systems (a 48 percent decrease), Quality Management (a 40 percent decrease), Reinsurance (a 100 percent decrease), and Third Party Liability (100 percent decrease) categories. Additionally, the Authorization and Denial/Grievance System category also showed improvement through a reduction in the percentage of required CAPs, although the decrease was somewhat smaller (19 percent). These improvements were tempered by the opportunities for improvement noted in the proportional increase in required CAPs for the Maternal/Child Health (a 16 percent increase) and Medical Management (zero to one CAP) categories. Of note, the Delivery System category did not require a CAP in either CYE 2006 or CYE 2007.

Strengths

All of the reviewed standards within the Delivery System, Reinsurance, and Third Party Liability categories were assessed to be in full compliance with AHCCCS's technical standards. These areas were identified as a recognized strength for MHP. Additional strengths were also identified within the Claim Systems, Delivery System, Authorization and Denial/Grievance System, Quality Management, and Third Party Liability categories based on the large improvement in the number of CAPs required between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from MHP's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: developing, clarifying, and revising MHP's policies and procedures and enhancing monitoring of performance results of MHP's internal programs and provider services. For example, AHCCCS recommended that MHP develop policies defining requirements and procedures for implementing required CAPs for providers (Behavioral Health), credentialing organizational providers (Quality Management), and reviewing new technology (Medical Management), as well as update its member rights and responsibilities document (Member Services). AHCCCS also recommended that MHP update its polices related to internal processes such as ensuring the qualifications of multilingual staff (Cultural Competency/Limited English Proficiency), loading contracts (General Administration/Corporate Compliance), and evaluating expedited requests for authorization and sending notices for extending decision timelines (Authorization and Denial/Grievance Systems. These recommendations highlight the need for MHP to evaluate its current policymaking processes and ensure that all policies and procedures address AHCCCS requirements. Additionally, MHP should ensure that all documents are written in commonly understood language for both members and providers. Establishing a strategy for developing comprehensive, clear, and concise policies in all operational areas will not only ensure MHP's policies and procedures comply with AHCCCS's standards, but also lead to more efficient operations.

AHCCCS also recommended that MHP improve its monitoring of providers' compliance with behavioral health standards (Behavioral Health), encounter data submission (Encounters), the effectiveness of its interventions for improving performance for AHCCCS-required measures, and PCP use of the PEDS tool (Maternal/Child Health). Together, these recommendations highlight the importance of establishing a comprehensive strategy of monitoring performance across all operational areas. It is highly recommended that MHP evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Behavioral Health, Encounters, Maternal/Child Health, and Quality Management.

- **Behavioral Health:** Overall, 40 percent of the reviewed standards (4 of the 10 standards) required a CAP in CYE 2007. All four of the required CAPs addressed effective monitoring of PCP compliance with behavioral health standards and developing policies for implementing required provider CAPs to address provider noncompliance. Specifically, MHP's required CAPs should ensure providers are maintaining members' behavioral health information in medical records, responding to Regional Behavioral Health Authority (RBHA) requests in a timely manner, and coordinating care for members with specific behavioral health needs. These findings outline an important opportunity to improve effective coordination-of-care activities and communication between physical and behavioral health providers. To address these deficiencies, MHP should appoint a time-limited work group to develop a comprehensive behavioral health monitoring program. This work group should involve both physical and behavioral health

personnel to identify effective strategies for monitoring coordination of care. Once processes are established, they should be formalized and accountabilities assigned to facilitate regular reporting and review of findings. The work group should also evaluate existing best practices to establish meaningful required provider CAPs when providers are found to be noncompliant, and to support providers in complying with the requirements.

- **Encounters**: Among the reviewed categories, standards in the Encounters category were assessed as being the least compliant. Specifically, 55 percent of the reviewed standards (6 of the 11 standards) required a CAP in CYE 2007. In general, the findings from this review highlight the need for MHP to evaluate and continue to monitor its compliance with half of the standards in this category. However, low compliance levels for these indicators appeared to be attributable to outlier data in the rolling-month measurement period and not system-based issues with the Contractor's ability to track and audit adjudicated, denied, deleted, and pended encounters. AHCCCS is currently implementing system upgrades to assist Contractors in data submission and approval and has scheduled meetings to provide additional technical assistance to address this timeliness and access issue. It is recommended that the Contractor participate with AHCCCS in these improvement activities and make applicable system adjustments to ensure timely, accurate, and complete submission of encounter data. Additionally, if submission problems continue, it is recommended that MHP conduct a root-cause analysis to evaluate internal data system issues that could be affecting the submission of data.
- **Maternal/Child Health:** Overall, 50 percent of the reviewed standards (three of the six standards) required a CAP in CYE 2007. In general, AHCCCS's review indicated that while MHP had an effective case management process in place to ensure that high-risk pregnant members received needed care and services, the Contractor failed to have an effective system for monitoring maternity program outreach activities. Additionally, CAPs were required related to performance in directly referring members to AzEIP and the failure to monitor providers' use of the PEDS tool. It is recommended that MHP establish a time-limited work group to design and implement a comprehensive maternal/child health performance monitoring program. Building upon existing programs that monitor ongoing prenatal and postpartum visits, the work group should identify and recommend effective methods and measures for tracking and evaluating the effectiveness of MHP's maternity outreach program. Additionally, MHP should use this work group to develop effective strategies for monitoring providers' compliance in using the PEDS tool. By developing a comprehensive strategy for monitoring and oversight of the maternal/child health program, MHP will generate increased information upon which continuous quality improvement can be established. Finally, MHP should take aggressive actions to revise and correct its policies and procedures regarding the referral of members to AzEIP.
- **Quality Management:** In CYE 2007, 4 of the 10 reviewed standards (40 percent) in the Quality Management category required a CAP. Two of these CAPs addressed the implementation of CAPs and subsequent monitoring/evaluation of interventions based on ongoing measurement of AHCCCS-mandated performance measures. The two remaining CAPs were related to developing and implementing internal policies and procedures (i.e., peer review and organizational provider credentialing). It is recommended that MHP establish an internal work group to evaluate its current processes for collecting, reporting, and evaluating the progress of interventions and quality improvement activities based on performance measure and PIP performance results. The work group should focus on identifying effective mechanisms to integrate its evaluation of performance results into a continuous quality improvement process. Moreover, these processes should be formalized and identified as a key function of MHP's

Quality Management Committee. Guidance for this process can be found in the CMS protocol for conducting performance improvement projects.[6-7] Additionally, the Contractor should conduct a review of its policies and procedures to ensure that complete policies are in place and in full compliance with AHCCCS standards. Finally, the Contractor should take the appropriate measures to formalize the annual review of policies and procedures to monitor their ongoing compliance with AHCCCS standards.

Summary

In general, MHP's compliance with AHCCCS's operational and financial standards somewhat improved in CYE 2007, although the change was not statistically significant. Additionally, while some individual categories (i.e., Claim Systems, Delivery System, General Administration and Corporate Compliance, Medical Management, Member Services, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, considerable opportunities for improvement were observed in others (i.e., the Behavioral Health, Encounters, Maternal/Child Health, and Quality Management categories). Notably, all the standards within the Delivery System, Reinsurance, and Third Party Liability categories were assessed to be in full compliance and were recognized as strengths for MHP.

[6-7] Conducting Performance Improvement Projects (Final Protocol Version 1.0, May 1, 2002, from CMS).

Mercy Care Plan

MCP serves eligible, enrolled members in GSA 2 (La Paz and Yuma counties), GSA 6 (Yavapai County), GSA 10 (Pima County), GSA 12 (Maricopa County), GSA 14 (Graham and Greenlee counties), and limited ZIP Codes in GSA 4 (Coconino County—86336 and 83640) and GSA 8 (Pinal County—85220 and 85242). The Contractor has contracted with AHCCCS since 1983 and had approximately 250,200 Acute Care members at the time of this annual review.

Findings

Figure 6-5 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-5—Categorized Levels of Compliance With Technical Standards for MCP[6-8]

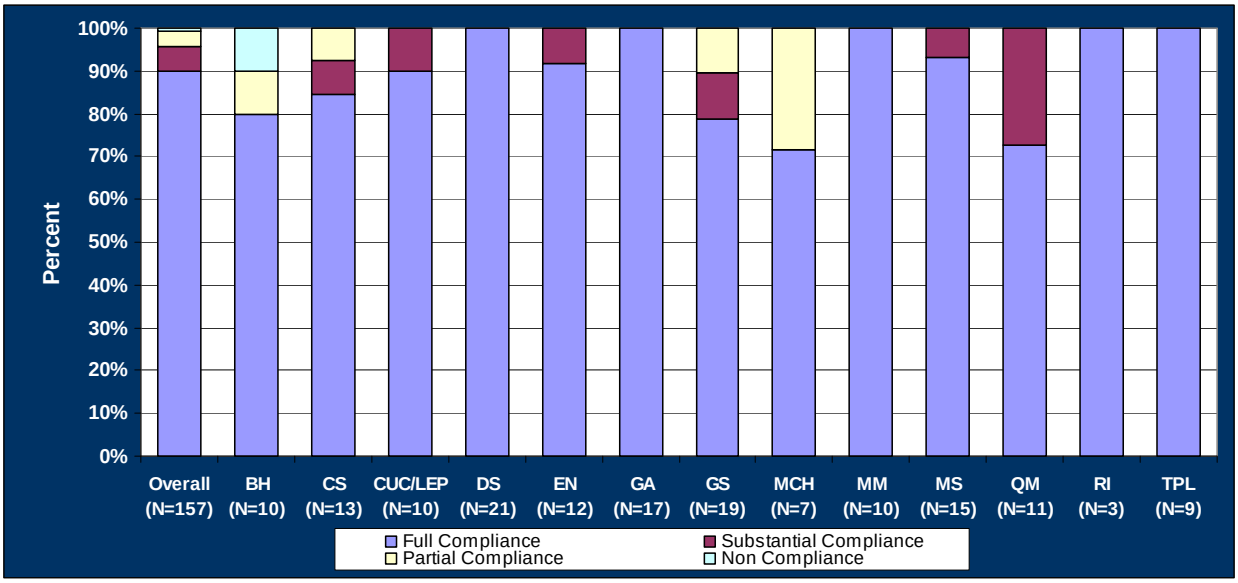


Figure 6-5 shows that MCP was in full compliance with 90 percent of the 157 reviewed standards (left-most bar), with some variation in performance across the categories. Overall, the percentage of each category that was in full compliance ranged from 71 percent (Maternal/Child Health) to 100 percent (Delivery System, General Administration/Corporate Compliance, Medical Management, Reinsurance, and Third Party Liability). In addition to the five categories in full compliance with 100 percent of the reviewed standards, the Claim Systems, Cultural Competency/Limited English Proficiency, Encounters, and Member Services categories were each assessed as having at least 85

[6-8] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

percent of the reviewed standards in full compliance. Following the Maternal/Child Health category (71 percent in full compliance), the Quality Management category represented the area with the next-greatest opportunity for improvement (73 percent).

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Authorization and Denial/Grievance category for MCP. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-9 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-9—Corrective Action Plans By Category *for* MCP

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	2	12%	10	20%
Claim Systems	2	12%	13	15%
Cultural Competency/Limited English Proficiency	1	6%	10	10%
Delivery System	0	0%	21	0%
Encounters	1	6%	12	8%
General Administration/Corporate Compliance	0	0%	17	0%
Authorization and Denial/Grievance System	5	29%	19	26%
Maternal/Child Health	2	12%	7	29%
Medical Management	0	0%	10	0%
Member Services	1	6%	15	7%
Quality Management	3	18%	11	27%
Reinsurance	0	0%	3	0%
Third Party Liability	0	0%	9	0%
Overall	**17**	**101%**	**157**	**11%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-9 shows that the category with the largest proportion of CAPs was Authorization and Denial/Grievance System, with 29 percent (5 out of 17) of the required CAPs, followed by the Quality Management category (18 percent). Notably, five categories did not require any CAPs (Delivery System, General Administration/Corporate Compliance, Medical Management, Reinsurance, and Third Party Liability), and only one CAP each was required for the Cultural Competency/Limited English Proficiency, Encounters, and Member Services categories. Based on the proportion of standards requiring a CAP within a category, the Maternal/Child Health category exhibited the greatest opportunity for improvement since 29 percent of the reviewed standards required a CAP. This category was followed by the Quality Management and Authorization and Denial/Grievance categories, for which about one-quarter of the reviewed standards required CAPs (27 percent and 26 percent, respectively). Overall, 17 of the 157 reviewed standards (11 percent) required a CAP in CYE 2007.

Table 6-10 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-10—Two-Year CAP Overview *for* MCP

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	4	29%	13	2	15%
Delivery System	10	1	10%	21	0	0%
Authorization and Denial/Grievance System	22	7	32%	19	5	26%
Maternal/Child Health	7	1	14%	7	2	29%
Medical Management	5	1	20%	10	0	0%
Quality Management	3	0	0%	11	3	27%
Reinsurance	4	3	75%	3	0	0%
Third Party Liability	10	3	30%	9	0	0%
Overall	**75**	**20**	**27%**	**93**	**12**	**13%**

Overall, Table 6-10 indicates that MCP's performance significantly improved (p=.024) from CYE 2006 (27 percent) to CYE 2007 (13 percent). Among the eight overlapping categories, MCP was able to resolve all of the CYE 2006 required CAPs for the following categories: Delivery System, Medical Management, Reinsurance, and Third Party Liability. Each of these categories had at least one CAP in CYE 2006, but no required CAPs in CYE 2007. Moreover, the Claim Systems and Authorization and Denial/Grievance System categories also demonstrated improvement based on the relative decrease in the percentage of required CAPs between the CYE 2006 and CYE 2007 reviews (a 48 percent decrease and 19 percent decrease, respectively). However, Table 6-10 also highlighted some opportunities for improvement based on the proportional increase in the required CAPs for the Maternal/Child Health (a 107 percent increase) and Quality Management (from zero to three CAPs) categories.

Strengths

All of the reviewed standards within the Delivery System, General Administration/Corporate Compliance, Medical Management, Reinsurance, and Third Party Liability categories were assessed to be in full compliance with AHCCCS's technical standards. These areas were identified as strengths for MCP. Additional strengths were identified within the Claim Systems and Authorization and Denial/Grievance System categories based on the large improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from MCP's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlighted several underlying opportunities for improvement—i.e., the revision of MCP's policies, procedures, and informational materials to reflect AHCCCS requirements. For example, AHCCCS recommended that MCP update materials outlining members' rights to translation services (Cultural Competency/Limited English Proficiency), modify existing authorization notices to ensure they are written in easily understood language and reference correct contract language (Authorization and Denial/Grievance System), and update its peer-review policy (Quality Management). Although not extensive, these recommendations highlight the importance of evaluating MCP's current policymaking processes to ensure that all policies and procedures address all AHCCCS requirements. Additionally, MCP should review its documents to ensure that that they are written in commonly understood language. Establishing a corporatewide strategy to develop comprehensive, clear, and concise policies in all operational areas will not only help MCP ensure its compliance with AHCCCS's standards, but should also lead to more efficient operations.

AHCCCS also recommended that MCP improve its monitoring of provider compliance with behavioral health standards (Behavioral Health) and PCP use of the PEDS tool (Maternal/Child Health). It is recommended that MCP evaluate its monitoring processes, assignment of accountabilities, and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance System, Maternal/Child Health, and Quality Management.

- **Authorization and Denial/Grievance System:** Overall, 26 percent (5 out of 19 standards) of the reviewed standards in this category required a CAP in CYE 2007. The five required CAPs highlighted areas where MCP should improve documentation (i.e., HCBS denials), modify policies to reflect AHCCCS requirements and timelines (i.e., notices of extension of timelines and claim disputes), and ensure policies and procedures are written in commonly understood language (i.e., pharmacy and HCBS notices). One CAP also identified an opportunity for improvement in MCP's notification of providers when expedited authorizations do not meet criteria. In general, authorization notices should be grounded in clear and concise policies, processes, and procedures, and communicated in commonly understood language and formats. In most cases, minor modifications to existing documents and processes should enable MCP to move into full compliance with AHCCCS standards. To address these deficiencies, MCP should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are noted, MCP should make the needed revisions/clarifications and/or add additional detail to documents to bring them into alignment with AHCCCS standards. Additionally, the Contractor should consider using current software to develop document templates that can be integrated with reminder systems to assist in notifying members and providers of authorization processes and actions/decisions.
- **Maternal/Child Health:** Of the seven standards reviewed in CYE 2007, two (29 percent) required a CAP. Both of the CAPs in this category highlighted opportunities for improvement in

monitoring PCP use of the PEDS tool for members in neonatal intensive care following birth and in Pima County members participating in the childhood obesity program. Additionally, these CAPs identified the need to enhance current procedures for coordinating care for members when needs are identified using the PEDS tool or through their participation in the childhood obesity program. As noted in AHCCCS's review, MCP has policies and procedures in place to monitor utilization and performance in other compliance categories. It is recommended that MCP form an internal work group to evaluate its current and effective monitoring programs and to identify efficient mechanisms to expand these activities to include monitoring maternal and child health program performance. This work group should also address mechanisms for monitoring coordination of member care activities. One approach might be to develop an automated alert system that notifies key staff members when performance reaches a predefined level or when an event requiring intervention is noted.

- **Quality Management:** The required CAPs for this category addressed deficiencies in the level of documentation maintained by the Contractor in two primary areas: for credentialing and recredentialing, documentation of required referrals to regulatory boards; for Quality Management Committee meeting minutes, documentation of review and subsequent action taken based on monitoring the results of interventions. MCP should establish either a time-limited committee or assign accountability to an existing committee responsible for implementing organizationwide strategies for improving documentation of department and committee activities. At a minimum, this committee should define corporate expectations for acceptable levels of documentation and ensure that documentation procedures are in alignment with AHCCCS standards. The committee should establish written operational policies and procedures to formalize the documentation requirements and processes. The committee should also consider designing standardized forms for documenting required actions and should formally communicate and review the requirements with all staff. Establishing formalized processes and methods for documenting required actions should assist in developing an organizationwide culture that supports efficient, effective, and compliant documentation.

  A third CAP required MCP to revise its peer-review policy to more clearly delineate the role of the chief medical officer. MCP should use the appropriate staff/committee to review, revise, and re-approve/re-issue its peer-review policy to ensure that it clearly describes the role of the chief medical officer related to peer-review processes and results.

Summary

In general, MCP's compliance with AHCCCS's operational and financial standards improved significantly in CYE 2007 (p=.024). While some individual categories (i.e., Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, General Administration/Corporate Compliance, Medical Management, Member Services, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, a few opportunities for improvement were noted in others (i.e., the Authorization and Denial/Grievance System, Maternal/Child Health, and Quality Management categories). Notably, all the standards within the Delivery System, General Administration/Corporate Compliance, Medical Management, Reinsurance, and Third Party Liability categories were assessed to be in full compliance and were recognized as strengths for MCP.

Pima Health Systems

PHS serves eligible members in GSA 10 (Pima and Santa Cruz counties) and has contracted with AHCCCS since October 1, 1983. At the time of this review, the Contractor had approximately 27,175 Acute Care members.

Findings

Figure 6-6 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-6—Categorized Levels of Compliance with Technical Standards for PHS[6-9]

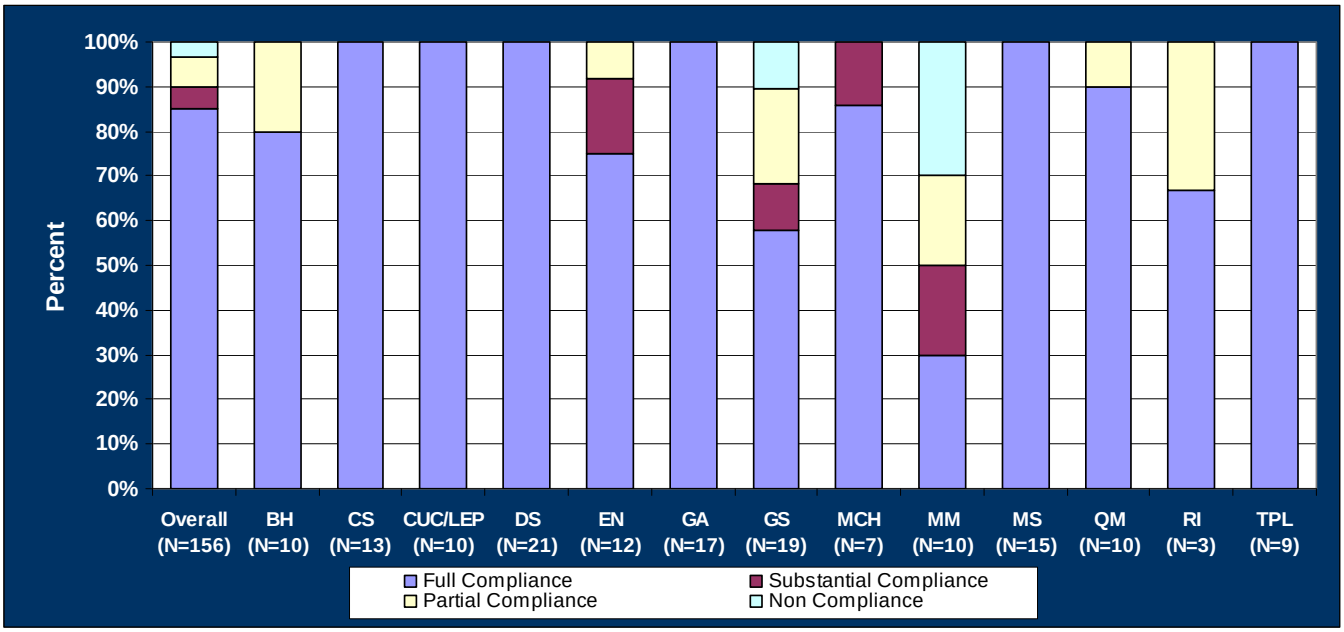


Figure 6-6 shows that PHS was in full compliance with 85 percent of the 156 reviewed standards (left-most bar), with considerable variation in performance across the individual categories. The percentage of each category that was in full compliance ranged from 30 percent (Medical Management) to 100 percent (Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Member Services, and Third Party Liability). In addition to the six categories in full compliance with 100 percent of the reviewed standards, the Maternal/Child Health and Quality Management categories were assessed as having at least 85 percent of the reviewed standards in full compliance. Following the Medical Management category (30 percent in full compliance), the Authorization and Denial/Grievance

[6-9] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

System category represented the area with the next-greatest opportunity for improvement (58 percent in full compliance).

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Claim Systems category for PHS. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-11 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-11—Corrective Action Plans By Category *for* PHS

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	2	8%	10	20%
Claim Systems	2	8%	13	15%
Cultural Competency/Limited English Proficiency	0	0%	10	0%
Delivery System	0	0%	21	0%
Encounters	3	12%	12	25%
General Administration/Corporate Compliance	0	0%	17	0%
Authorization and Denial/Grievance System	8	32%	19	42%
Maternal/Child Health	1	4%	7	14%
Medical Management	7	28%	10	70%
Member Services	0	0%	15	0%
Quality Management	1	4%	10	10%
Reinsurance	1	4%	3	33%
Third Party Liability	0	0%	9	0%
Overall	**25**	**100%**	**156**	**16%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-11 shows that the Authorization and Denial/Grievance System category had the largest proportion of CAPs, with 32 percent (8 out of 25) of the required CAPs, followed by the Medical Management category (28 percent). Notably, five categories did not require any CAPs (Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Member Services, and Third Party Liability) and only one CAP was required for the Maternal/Child Health, Quality Management, and Reinsurance categories. Based on the proportion of standards requiring a CAP within a category, the Medical Management and Authorization and Denial/Grievance System categories exhibited the greatest opportunity for improvement with 70 percent and 42 percent of the reviewed standards requiring a CAP, respectively. Overall, 25 of the 156 reviewed standards (16 percent) required a CAP in CYE 2007.

Table 6-12 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-12—2-Year CAP Overview *for* PHS

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	1	7%	13	2	15%
Delivery System	11	0	0%	21	0	0%
Authorization and Denial/Grievance System	22	0	0%	19	8	42%
Maternal/Child Health	7	0	0%	7	1	14%
Medical Management	5	2	40%	10	7	70%
Quality Management	3	0	0%	10	1	10%
Reinsurance	4	4	100%	3	1	33%
Third Party Liability	10	1	10%	9	0	0%
Overall	**76**	**8**	**11%**	**92**	**20**	**22%**

Overall, Table 6-12 indicated that PHS's performance declined from CYE 2006 (11 percent) to CYE 2007 (22 percent), although the decrease was not statistically significantly (p=.052). Among the eight overlapping categories, PHS was able to resolve the required CYE 2006 CAP for the Third Party Liability category. This category had one CAP required in CYE 2006, but no CAPs required in CYE 2007. Table 6-12 showed relative improvement in the Reinsurance category, moving from four CAPs in CYE 2006 to only one in CYE 2007. Notably, CAPs were not required for any of the reviewed standards for the Delivery System category in either review year. The table also highlighted some opportunities for improvement based on the proportional increase in the required CAPs for the Claim Systems, Authorization and Denial/Grievance System, Maternal/Child Health, and Medical Management categories. These opportunities for improvement considerably exceed the noted improvements.

Strengths

All of the reviewed standards within the Claims Systems, Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Member Services, and Third Party Liability categories were assessed as being in full compliance with AHCCCS's technical standards. Performance for these areas was a recognized strengths for PHS. Additional strengths were also identified within the Reinsurance category based on the improvement in the number of required CAPS noted between CYE 2006 and CYE 2007. Of note is the consistent performance of PHS for the Delivery System category, which had no required CAPs in either CYE 2006 or CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from PHS's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: incorporating required language in policies/documents and enhancing monitoring activities. For example, AHCCCS recommended that PHS revise its policies and notification letters to include required elements such as correct dates, titles, and timelines in authorization notices and process letters (Authorization and Denial/Grievance Systems); add appropriate dispute and appeal citations to remittance advice letters (Claims System); strengthen and add detail to its emergency services policy and interrater reliability methodology; and develop practice guidelines (Medical Management). These recommendations indicate the need to develop a systemwide approach to effective policymaking that focuses first on drafting documents that are in alignment with AHCCCS requirements and are written in commonly understood language. AHCCCS also recommended that PHS improve monitoring of its authorization, denial, and grievance system's (Authorization and Denial/Grievance Systems) performance; provider compliance (Behavioral Health); member utilization and disease management outcomes (Medical Management); and encounter data submission (Encounters). Establishing a strategy for developing comprehensive, clear, and concise policies in all operational areas, coupled with appropriate oversight and monitoring, should enhance PHS's compliance with AHCCCS's standards and lead to more efficient operations.

HSAG's review supports those recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Authorization and Denial/Grievance Systems and Medical Management.

- **Authorization and Denial/Grievance System:** More than 40 percent of the reviewed standards in this category (8 out of 19 standards) required a CAP in CYE 2007. Of these standards, seven of the eight required CAPs were within the first seven standards. These standards relate to the Contractor's required timing and actions related to prior authorizations, continued-stays, member-specific information regarding member rights related to authorization decisions/actions, and the accuracy of several Contractor notices. These findings outline an important opportunity to improve an aspect of health care that is central to member health and member/provider satisfaction. Service authorization processes, timelines, decisions, and the associated notices of action should be grounded in clear, concise, and compliant policies, processes, and procedures. Additionally, relevant notices and letters should be written in commonly understood language and formats. In most cases, minor modifications to existing documents and processes would enable PHS to move into full compliance with the AHCCCS standards for which CAPs were required.

  To address these deficiencies, PHS should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are identified, PHS should take corrective actions to revise the documents and associated processes to bring them into alignment with AHCCCS standards. Additionally, PHS should review its current notification flow process related to authorization and denial/grievance systems and identify the points where enhanced monitoring can be implemented to ensure all timeliness standards are met. Finally, current documentation standards should be reviewed, updated, and augmented as appropriate to ensure denial decisions are clearly supported in case files/records. Implementing and promoting an organizationwide culture of effective

documentation is an essential and effective strategy for implementing change and ensuring compliance with applicable standards/requirements.

- **Medical Management:** With 70 percent of the reviewed standards (7 out of 10 standards) requiring a CAP, the entire category of Medical Management is an opportunity for improvement for PHS. Opportunities for improvement included: implementing a comprehensive monitoring program for reviewing member utilization, designing management interventions and mechanisms to support member and provider profiling, increasing the effectiveness of care coordination and case management for members with special health care needs, expanding interrater reliability processes, and revising/adding more detail to PHS's policies and procedures that address emergency services and development of practice guidelines.

  To address these required actions, it is recommended that PHS form an inter-departmental work group to evaluate the current structure of its Medical Management program. In addition to developing an aggressive schedule for resolving system-related barriers to utilization reporting, the work group should identify ways to incorporate scientific rigor into its medical management activities, including the enhancement of current interrater reliability programs to ensure evaluation tools are comprehensive and capable of discerning the ability of nurses to make clinical decisions consistently and accurately. Additionally, industry standards for measuring disease management outcomes should be incorporated into ongoing monitoring programs, including member utilization and member/provider profiles. Implementing aggressive monitoring and reporting strategies and policy revisions should not only bring PHS into greater compliance with AHCCCS standards, but also assist it in delivering effective care to its members. It is also recommended that the work group review PHS's medical management policies and procedures. Specifically, each policy should be crosswalked to the associated AHCCCS standards to ensure all required language and processes are clearly and concisely documented. In many cases, PHS would benefit from simply enhancing its current policies by making them more detailed and comprehensive. Finally, PHS should consider modifying the Medical Management Committee processes to facilitate and ensure complete documentation of activities conducted and decisions made by this group. This could include developing a standardized form for structuring, tracking, and documenting discussions during committee meetings.

Summary

In general, PHS's compliance with AHCCCS's operational and financial standards decreased somewhat in CYE 2007, although not significantly. While 85 percent of the reviewed standards were assessed as being in full compliance, the percentage of required CAPs increased from CYE 2006 to CYE 2007. Additionally, while some individual categories (i.e., Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Maternal/Child Health, Member Services, Quality Management, and Third Party Liability) exhibited a high percentage of standards in full compliance, several opportunities for improvement were noted for others (i.e., Authorization and Denial/Grievance System and the Medical Management). Notably, all the standards within the Claims Systems, Cultural Competency/Limited English Proficiency, Delivery System, General Administration/Corporate Compliance, Member Services, and Third Party Liability categories were assessed to be in full compliance and were recognized strengths for PHS.

Phoenix Health Plan

PHP serves eligible, enrolled members in GSAs 8 (Pinal and Gila counties) and 12 (Maricopa County) and has contracted with AHCCCS since 1983. At the time of this review, the Contractor had approximately 91,000 members.

Findings

Figure 6-7 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-7—Categorized Levels of Compliance With Technical Standards PHP[6-10]

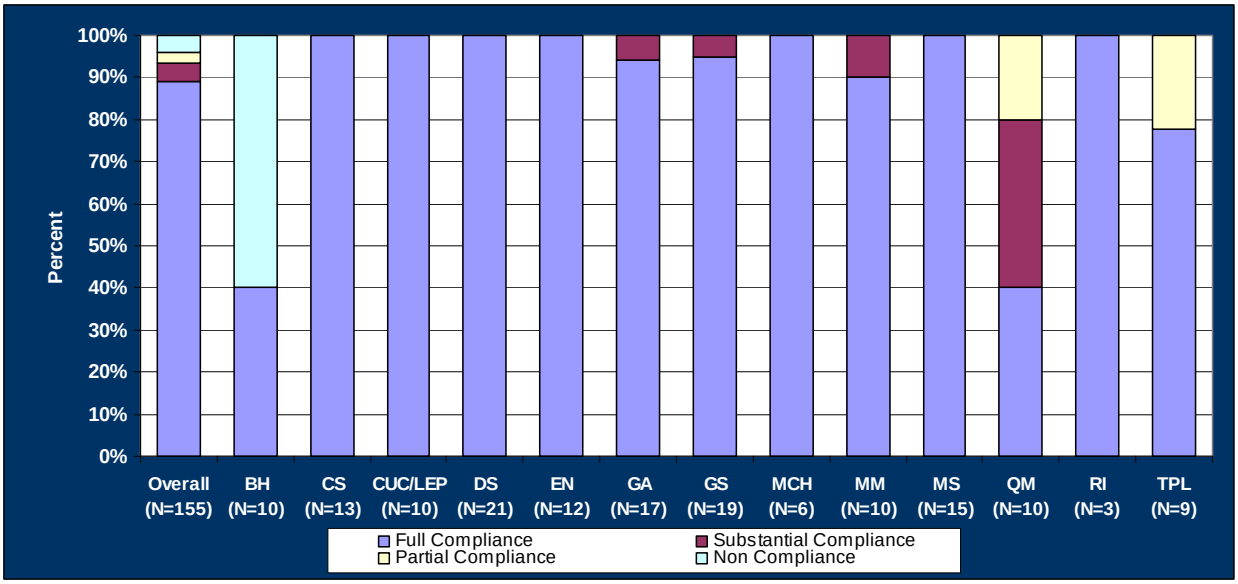


Figure 6-7 shows that PHP was in full compliance with 89 percent of the 155 reviewed standards (left-most bar), with some variation in performance across the categories. Overall, the percentage of each category that was in full compliance ranged from 40 percent (Behavioral Health and Quality Management) to 100 percent (Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, Maternal/Child Health, Member Services, and Reinsurance). In addition to the seven categories in full compliance with 100 percent of the reviewed standards, the General Administration/Corporate Compliance, Authorization and Denial/Grievance System, and Medical Management categories were assessed as having at least 85 percent of the reviewed standards in full compliance. The Behavioral Health and Quality Management categories (40 percent in full compliance) both showed considerable opportunity for improvement. However,

[6-10] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, TPL=Third Party Liability.

while all of the standards that were not fully compliant in the Behavioral Health category were scored as noncompliant, none of the standards that were not fully compliant in the Quality Management category were scored as noncompliant.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Authorization and Denial/Grievance System and Medical Management categories for PHP. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-13 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-13—Corrective Action Plans By Category *for* PHP

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	6	32%	10	60%
Claim Systems	0	0%	13	0%
Cultural Competency/Limited English Proficiency	0	0%	10	0%
Delivery System	0	0%	21	0%
Encounters	0	0%	12	0%
General Administration/Corporate Compliance	1	5%	17	6%
Authorization and Denial/Grievance System	2	11%	19	11%
Maternal/Child Health	0	0%	6	0%
Medical Management	2	11%	10	20%
Member Services	0	0%	15	0%
Quality Management	6	32%	10	60%
Reinsurance	0	0%	3	0%
Third Party Liability	2	11%	9	22%
Overall	**19**	**102%**	**155**	**12%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-13 shows that nearly two-thirds (64 percent, or 12 out of 19) of the required CAPs were evenly divided between the Behavioral Health and Quality Management categories. Notably, seven categories did not require any CAPs (Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, Maternal/Child Health, Member Services, and Reinsurance), and only one CAP was required for the General Administration/Corporate Compliance category. Based on the proportion of standards requiring a CAP within a category, the Behavioral Health and the Quality Management categories exhibited the greatest opportunity for improvement since 60 percent of the reviewed standards for each of the categories required a CAP. Overall, 19 of the 155 reviewed standards (12 percent) required a CAP in CYE 2007.

Table 6-14 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-14—Two-Year CAP Overview *for* PHP

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	4	29%	13	0	0%
Delivery System	11	0	0%	21	0	0%
Authorization and Denial/Grievance System	22	2	9%	19	2	11%
Maternal/Child Health	7	4	57%	6	0	0%
Medical Management	5	0	0%	10	2	20%
Quality Management	3	1	33%	10	6	60%
Reinsurance	4	4	100%	3	0	0%
Third Party Liability	10	1	10%	9	2	22%
Overall	**76**	**16**	**21%**	**91**	**12**	**13%**

Table 6-14 indicates that, overall, PHP's performance somewhat improved from CYE 2006 (21 percent) to CYE 2007 (13 percent), although the difference was not statistically significant (p=.175). Among the eight overlapping categories, PHP was able to resolve all of the required CYE 2006 CAPs for the following categories: Claim Systems, Maternal/Child Health, and Reinsurance. Each of these categories had at least one CAP in CYE 2006, but no CAPs were required in CYE 2007. None of the remaining categories demonstrated any improvement based on the relative decrease in the percentage of required CAPs since CYE 2006, although the number of CAPs required for the Authorization and Denial/Grievance System remained constant at two required CAPs. Table 6-14 also highlighted several opportunities for improvement based on the proportional increase in required CAPs for the Medical Management (zero to two CAPs), Quality Management (an 82 percent increase), and Third Party Liability (a 120 percent increase) categories. Notably, the Delivery System category did not require a CAP during either review year.

Strengths

All of the reviewed standards within the Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, Maternal/Child Health, Member Services, and Reinsurance categories were assessed as being in full compliance with AHCCCS's technical standards. These areas were recognized strengths for PHP. Of note is the consistent performance of PHP for the Delivery System category, which had no required CAPs in either CYE 2006 or CYE 2007. Additional strengths were also identified within the Claim Systems, Maternal/Child Health,

and Reinsurance categories based on the large improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from PHP's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories: developing, clarifying, and revising PHP's policies and procedures, and enhancing monitoring of its internal programs and provider services. For example, AHCCCS recommended that PHP develop or modify existing policies related to emergency services, credentialing of organizational providers, and evaluation of new technology, and incorporate successful interventions into planning activities (Medical Management and Quality Management), as well as update its provider manual to outline member rights (Quality Management). AHCCCS further recommended that PHP take appropriate steps to ensure that all documents for members and for providers are written in commonly understood language. These recommendations highlight the need for PHP to evaluate its current policymaking processes and ensure that all policies and procedures completely address all AHCCCS requirements. Establishing a strategy for developing comprehensive, clear, and concise policies in all operational areas should enhance PHP's compliance with AHCCCS's standards and lead to more efficient operations.

AHCCCS also recommended that PHP improve its monitoring of providers' compliance with behavioral health standards (Behavioral Health), information included in the contracts/claims payment system (General Administration/Corporate Compliance), and the incorporation of findings and results for AHCCCS-required performance measures and PIPs into PHP's quality management and improvement activities (Quality Management). Together, these recommendations highlight the importance of establishing a comprehensive strategy of monitoring performance across all operational areas. It is recommended that PHP evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Behavioral Health, and Quality Management.

- **Behavioral Health:** Overall, 60 percent (or 6 out of 10 standards) of the reviewed standards in CYE 2007 required a CAP. Of the six required CAPs, all of the reviewed standards were scored as noncompliant, suggesting considerable opportunities for improvement. In general, these required CAPs highlighted the need for PHP to effectively monitor PCP compliance with behavioral health standards and to develop policies/procedures for implementing provider-required CAPs to address provider noncompliance. Specifically, PHP is required to develop monitoring processes to ensure the providers are maintaining members' behavioral health information in medical records, responding to RBHA requests in a timely manner, documenting providers' review of members' behavioral health information, and coordinating care for members with specific behavioral health needs. These findings outline an important opportunity to improve effective coordination of care between physical and behavioral health providers.

To address these deficiencies, PHP should establish a time-limited work group to develop a comprehensive behavioral health monitoring program. This work group should involve both physical and behavioral health personnel to identify effective strategies for monitoring the coordination of care and sharing of patient information. Once processes are established, they should be formalized and accountabilities assigned to a committee to facilitate regular reporting and review of findings. This committee should also evaluate existing best practices to identify effective CAPs when providers are found to be noncompliant and to support them in improving performance. This or another existing committee should be charged with developing effective mechanisms for rapid-cycle, ongoing monitoring of provider performance to be used until such time as performance reaches acceptable levels. A potentially effective strategy for enhancing performance is for PHP to strengthen the processes and resources available to providers for appropriately sharing electronic health/medical records among physical and behavioral health providers. This action may result in improved coordination between providers and member care and services through enhanced communication.

- **Quality Management:** In CYE 2007, 6 of the 10 reviewed standards in the Quality Management category required a CAP. Three of these CAPs addressed the need to continue PHP's current implementation of required CAPs and conduct ongoing monitoring/evaluation of the effectiveness of interventions based on its performance on AHCCCS-mandated performance measures and PIPs. The two additional required CAPS were both related to developing and implementing internal policies and procedures (i.e., communication of resolution to member appeals/grievances and credentialing organizational providers).

  It is recommended that PHP establish an internal work group to evaluate its current processes for collecting, reporting, and evaluating the progress of interventions and quality improvement activities based on PHP's performance for AHCCCS-required measures and PIPs. The work group should focus on identifying effective mechanisms to use the results of causal/barrier analyses and implementing interventions in a continuous quality improvement process. Moreover, these processes should be formalized and identified as a key function of PHP's Quality Management Committee. Guidance for this process can be found in the CMS protocol for conducting PIPs.[6-11] Additionally, the Contractor should conduct a review of its policies and procedures to ensure that complete policies are in place and in full compliance with AHCCCS standards. Finally, the Contractor should formalize the annual review of policies and procedures to ensure their continued compliance with AHCCCS standards.

Summary

In general, PHP's compliance with AHCCCS's operational and financial standards somewhat improved in CYE 2007, although not significantly. Additionally, while some individual categories (i.e., Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, General Administration/Corporate Compliance, Authorization and Denial/Grievance System, Maternal/Child Health, Member Services, and Reinsurance) exhibited a high percentage of standards in full compliance, a few opportunities for improvement were observed in others (i.e., Behavioral Health and Quality Management). Notably, all the standards within the Claim Systems, Cultural Competency/Limited English Proficiency, Delivery System, Encounters, Maternal/Child Health, Member Services, and Reinsurance categories were assessed to be in full compliance and were recognized as a strength for PHP.

[6-11] Conducting Performance Improvement Projects (Final Protocol Version 1.0, May 1, 2002, from CMS).

University Family Care

UFC serves eligible, enrolled members in GSA 10 (Pima County) and has contracted with AHCCCS since October 1, 1997. At the time of this review, the Contractor had approximately 8,200 members.

Findings

Figure 6-8 presents the overall compliance results (i.e., far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-8—Categorized Levels of Compliance With Technical Standards for UFC[6-12]

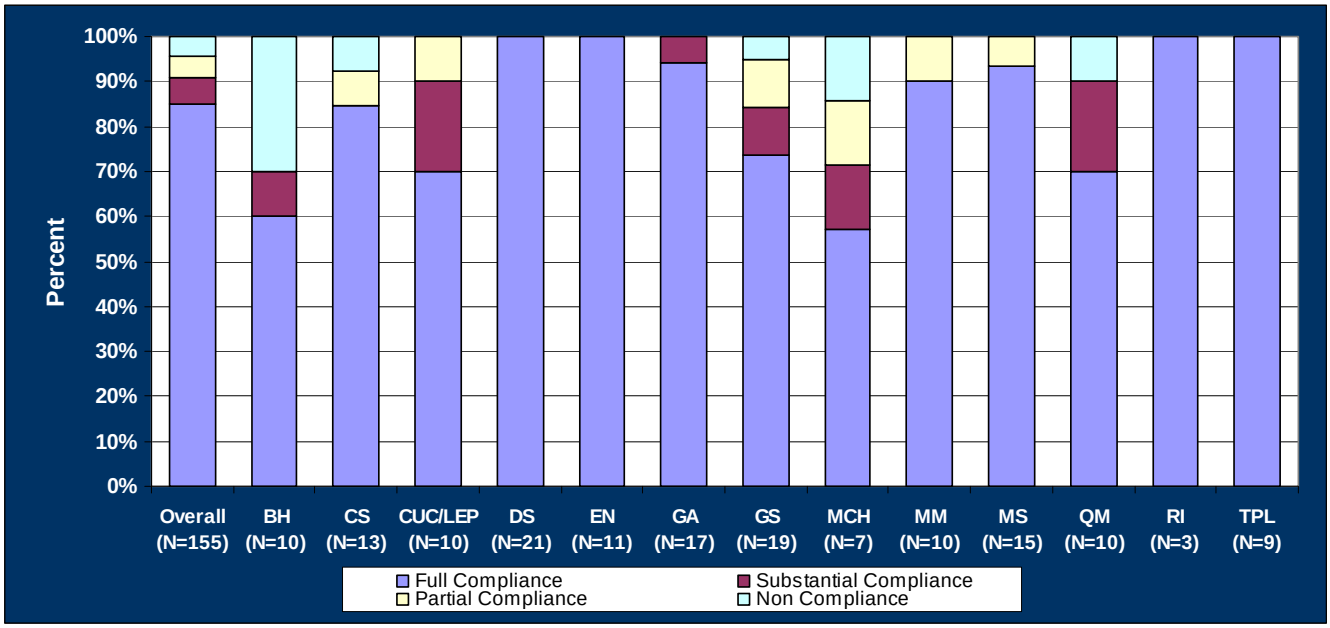


Figure 6-8 shows that UFC was in full compliance with 85 percent of the 155 reviewed standards (left-most bar), with moderate variation in performance across the categories. Overall, the percentage of each category that was in full compliance ranged from 57 percent (Maternal/Child Health) to 100 percent (Delivery System, Encounters, Reinsurance, and Third Party Liability). In addition to the four categories in full compliance with 100 percent of the review standards, the Claim Systems, General Administration/Corporate Compliance, Medical Management, and Member Services categories were assessed as having at least 85 percent of the reviewed standards in full compliance. Following the Maternal/Child Health category (57 percent in full compliance), the Behavioral Health category represented the area with the next-greatest opportunity for improvement (60 percent).

[6-12] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced. This situation occurred in the Claim Systems, Maternal/Child Health, and Member Services categories for UFC. For this reason, the total number of CAPs is not always equal to the total number of reviewed standards not in full compliance. Table 6-15 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-15—Corrective Action Plans By Category *for* UFC

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	4	15%	10	40%
Claim Systems	4	15%	13	31%
Cultural Competency/Limited English Proficiency	3	11%	10	30%
Delivery System	0	0%	21	0%
Encounters	0	0%	11	0%
General Administration/Corporate Compliance	1	4%	17	6%
Authorization and Denial/Grievance System	5	19%	19	26%
Maternal/Child Health	4	15%	7	57%
Medical Management	1	4%	10	10%
Member Services	2	7%	15	13%
Quality Management	3	11%	10	30%
Reinsurance	0	0%	3	0%
Third Party Liability	0	0%	9	0%
Overall	**27**	**101%**	**155**	**17%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-15 shows that the Authorization and Denial/Grievance System category had the largest proportion of CAPs, with 19 percent (5 out of 27) of the required CAPs, followed by the Behavioral Health, Claim Systems, and Maternal/Child Health categories (15 percent each). Notably, four categories did not require any CAPs (Delivery System, Encounters, Reinsurance, and Third Party Liability) while only one CAP was required for the General Administration/Corporate Compliance and Medical Management categories. Based on the proportion of standards requiring a CAP within a category, the Maternal/Child Health category exhibited the greatest opportunity for improvement since 57 percent of the reviewed standards required a CAP. This category was followed by the Behavioral Health, Claim Systems, Cultural Competency/Limited English Proficiency, Quality Management, and Authorization and Denial/Grievance categories, for which at least one-quarter of the reviewed standards required CAPs (40 percent, 31 percent, 30 percent, 30 percent, and 26 percent, respectively). Overall, 27 of the 155 reviewed standards (17 percent) required a CAP in CYE 2007.

Table 6-16 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-16—Two-Year CAP Overview *for* UFC

Category	CYE 2006			CYE 2007		
	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	5	36%	13	4	31%
Delivery System	11	0	0%	21	0	0%
Authorization and Denial/Grievance System	22	7	32%	19	5	26%
Maternal/Child Health	7	3	43%	7	4	57%
Medical Management	5	0	0%	10	1	10%
Quality Management	3	2	67%	10	3	30%
Reinsurance	4	2	50%	3	0	0%
Third Party Liability	10	3	30%	9	0	0%
Overall	**76**	**22**	**29%**	**92**	**17**	**18%**

Overall, Table 6-16 indicates that UFC's performance somewhat improved from CYE 2006 (29 percent) to CYE 2007 (18 percent). Among the eight overlapping categories, UFC was able to resolve all of the required CYE 2006 CAPs for the following categories: Reinsurance and Third Party Liability. Each of these categories had at least one CAP required in CYE 2006, but no CAPs required in CYE 2007. Moreover, the Claim Systems, Authorization and Denial/Grievance System, and Quality Management[6-13] categories also demonstrated improvement based on the relative decrease in the percentage of required CAPs since CYE 2006 (a 14 percent decrease, 19 percent decrease, and 55 percent, respectively). However, Table 6-16 also highlighted an opportunity for improvement based on the proportional increase in the required CAPs for the Maternal/Child Health category (33 percent increase). Additionally, the Medical Management category required a CAP in CYE 2007 even though a CAP was not required in CYE 2006. Notably, the Delivery System category did not require a CAP during either review year.

[6-13] The results for the category show a relative improvement along with the number of CAPs increasing from two to three CAPs. This result is due to the relatively large increase in the number of standards reviewed in the current review cycle compared with the previous review (from 3 to 10 reviewed standards).

Strengths

Performance for all of the reviewed standards within the Delivery System, Encounters, Reinsurance, and Third Party Liability categories was assessed as being in full compliance with AHCCCS's technical standards. These areas were identified as recognized strengths for UFC. Of note is UFC's consistent performance for the Delivery System category as demonstrated by no required CAPs in either CYE 2006 or CYE 2007. Additional strengths were also identified within the Quality Management, Reinsurance, and Third Party Liability categories based on the large improvement noted between CYE 2006 and CYE 2007.

Opportunities for Improvement and Recommendations

In the final report generated from UFC's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories, including: developing, clarifying, and revising UFC's policies and procedures, and enhancing monitoring of UFC's internal programs and provider services. For example, AHCCCS recommended that UFC develop or modify existing policies related to credentialing organizational providers and evaluating new technologies, incorporate successful interventions into planning activities (Medical Management and Quality Management), and update its desktop procedures to outline required time frames for actions (General Administration/Corporate Compliance). UFC's required CAPs also highlighted the need to modify its existing authorization notices to ensure that they are written in easily understood language and reference required, correct contract language (Authorization and Denial/Grievance System); ensure that the member handbook is written in easily understood language (Member Services); and strengthen/add detail to its peer-review policy (Quality Management). These recommendations highlight the need for UFC to evaluate its current policymaking processes and to ensure that all policies and procedures completely and accurately address AHCCCS requirements. Establishing a strategy for developing a comprehensive, clear, and concise set of policies in all operational areas should help UFC ensure that it is in compliance with AHCCCS's standards and lead to more efficient operations.

AHCCCS also recommended that UFC improve its monitoring of providers' compliance with behavioral health standards (Behavioral Health), the auto-adjudication of claims (Claim Systems), the effectiveness of interventions and findings for performance measures (Quality Management), and its maternity outreach and childhood obesity programs (Maternal/Child Health). Together, these recommendations highlight the importance of establishing a comprehensive strategy of monitoring performance across all operational areas. It is recommended that UFC evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunity for improvement: Behavioral Health, Cultural Competency/Limited English Proficiency, Maternal/Child Health, and Quality Management.

- **Behavioral Health:** Overall, 40 percent (or 4 out of 10 standards) of the reviewed standards in CYE 2007 required a CAP. Of the four required CAPs, three of the reviewed standards were scored as noncompliant, suggesting considerable opportunity for improvement in this category. In general, these CAPs highlighted the need for UFC to effectively monitor PCP compliance with behavioral health standards and to develop policies and procedures for requiring CAPs to address areas of noncompliance. Specifically, UFC was required to develop monitoring processes to ensure the providers are maintaining members' behavioral health information in medical records, responding to RBHA requests in a timely manner, and coordinating care for members with specific behavioral health needs. These findings outline an important opportunity to improve effective coordination of care between physical and behavioral health providers.

  To address these deficiencies, UFC should establish a time-limited work group to develop a comprehensive behavioral health monitoring program. This work group should involve both physical and behavioral health personnel to identify effective strategies for monitoring coordination of care and sharing patient information. Once processes are established, they should be fully implemented and accountabilities assigned for regular monitoring and reporting of performance results, for identifying best practices to structure the required CAPs when providers are found to be noncompliant, and for supporting providers in improving their performance. A potentially effective strategy for enhancing performance in coordinating care is for UFC to strengthen the processes and resources available to its providers for appropriately sharing electronic health/medical records among physical and behavioral health providers. Electronic health/medical records can also be integrated into automated reminder systems, further assisting providers in managing patient care across physical and behavioral health providers. These strategies should result in improved coordination between providers and improved member care and services through enhanced communication.
- **Cultural Competency/Limited English Proficiency:** Overall, 30 percent (or 3 out of 10 standards) of standards reviewed in this category required a CAP. The three CAPs highlighted opportunities for improvement in UFC's internal processes for ensuring multilingual staff qualifications and the cultural competency of employees. While none of the standards were scored as noncompliant, the CAPs do highlight opportunities for improvement where UFC had only partially addressed and incorporated AHCCCS requirements into its operations. These findings highlighted some deficiencies in the management and implementation of UFC's Cultural Competency Program. It is recommended that the Contractor form an internal work group to conduct an assessment of the organizational and functional structure of its Cultural Competency Program. The focus of this work group should be to evaluate and take steps to formalize the hiring and management of multilingual staff to ensure all AHCCCS requirements for staff are met. Second, the work group should evaluate current policies and procedures as well as member and provider materials to ensure that information on the availability of translation services is readily available and that providers are aware of UFC's Cultural Competency Program and requirements. Additionally, the work group should identify appropriate measures and reporting for ongoing monitoring of the Cultural Competency Program, including identifying the appropriate committee or other body responsible for reviewing results and recommending and/or implementing changes.
- **Authorization and Denial/Grievance System:** More than one-quarter (26 percent) of the reviewed standards in this category (5 out of 19 standards) required a CAP in CYE 2007. Of these standards, all five required CAPs were within the first six standards. These standards highlighted opportunities for improvement in the process for evaluating expedited authorization

requests as well as the accuracy and completeness of several Contractor notices of action. These findings outline an important opportunity to improve an aspect of health care that is central to member health and member/provider satisfaction. Service authorization decisions and notices should be grounded in clear and concise policies and procedures. Additionally, relevant notices and letters should be written in commonly understood language and available in alternative formats. In most cases, minor modifications to existing documents and processes should enable UFC to move toward compliance with AHCCCS standards.

To address these deficiencies, UFC should convene an internal work group to cross-reference current policies and procedures with the associated AHCCCS requirements. When discrepancies or the need for clarification are identified, UFC should take corrective actions to revise the policies and bring them into alignment with AHCCCS standards. Additionally, UFC should review its current notification process flow related to authorization and denial/grievance systems, and identify the points where strengthened monitoring can be implemented to ensure all timeliness standards are met and documented. Developing an organizationwide culture of timely, accurate, and complete documentation is an important and effective strategy for implementing change and driving improved performance results.

- **Maternal/Child Health:** Of the seven standards reviewed in CYE 2007, four (57 percent) required a CAP, suggesting considerable opportunities for improvement. In general, AHCCCS's review indicated that while UFC had an effective case management process in place to ensure that high-risk pregnant members received needed care and services, the Contractor did not have an effective system to monitor maternity program outreach activities. Additionally, several CAPs were related to UFC's coordination with AzEIP and provider use of the PEDS tool. Finally, one CAP addressed educating providers on referrals of members to center of excellence obesity providers as well as monitoring members participating in the childhood obesity program.

  These CAPs underscore the importance of a comprehensive monitoring program designed to provide the Contractor with ongoing information related to its performance for the maternal and child health programs. It is recommended that UFC convene a time-limited work group to design and implement a comprehensive maternal/child health monitoring program. This work group should include cross-departmental staff familiar with other UFC monitoring programs and the data sources available for monitoring utilization. Once established, the work group should cross-reference AHCCCS requirements with current program activities/results and data sources and recommend effective methods and measures for tracking utilization and performance. At a minimum, efforts should be focused on the maternity outreach and childhood obesity programs. This work group should also discuss ways to link the monitoring of results with member care coordination and provider follow-up. One strategy could be to develop an automated alert system that notifies key staff when performance reaches a predefined level, or when an event requiring intervention is noted. Additionally, UFC should revise the associated policies and procedures, strengthen its coordination with AzEIP, and increase provider use of the PEDS tool. These activities should include strengthening provider education and information, monitoring and providing feedback related to provider performance, requiring provider CAPs, and providing examples of best practices for improving provider performance.
- **Quality Management:** In CYE 2007, 3 of the 10 reviewed standards (30 percent) in the Quality Management category required a CAP. One of these CAPs addressed the need to continue CAPs for those performance measures that remained below the AHCCCS MPS. The two remaining CAPs were both related to developing and implementing internal policies and procedures (i.e., peer review and credentialing organizational providers).

It is recommended that UFC establish an internal work group to evaluate its current processes for collecting, reporting, and evaluating the progress of interventions and quality improvement activities based on its performance results for AHCCCS-required measures. The work group should focus on identifying effective mechanisms for integrating the use of evaluation results in a continuous quality improvement process. Moreover, these processes should be formalized and identified as a key function of UFC's Quality Management/Performance Improvement (QM/PI) Committee. Additionally, the Contractor should conduct a review of its policies and procedures to ensure that complete policies are in place and in full compliance with AHCCCS standards. Finally, the Contractor should take the appropriate measures to formalize the annual review of policies and procedures to monitor ongoing compliance with AHCCCS standards.

Summary

In general, UFC's compliance with AHCCCS's operational and financial standards somewhat improved in CYE 2007. Additionally, while some individual categories (i.e., Delivery System, Encounters, General Administration/Corporate Compliance, Medical Management, Member Services, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, several opportunities for improvement were noted in others (i.e., the Cultural Competency/Limited English Proficiency, Behavioral Health, Authorization and Denial/Grievance System, Maternal/Child Health, and Quality Management categories). Notably, all the standards within the Delivery System, Encounters, Reinsurance, and Third Party Liability categories were assessed to be in full compliance and were recognized as strengths for UFC.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

DES/CMDP serves eligible, enrolled members in all GSAs and has contracted with AHCCCS since 2003. At the time of this review, the Contractor had approximately 9,400 members.

Findings

Figure 6-9 presents the overall compliance results (i.e., the far-left bar) and the results for each of 13 categories of OFR standards. Bars for the overall and category results are stacked according to the proportion of each category of standards in full, substantial, partial, and noncompliance, with full compliance on the bottom of the stacked bars.

Figure 6-9—Categorized Levels of Compliance With Technical Standards for DES/CMDP[6-14]

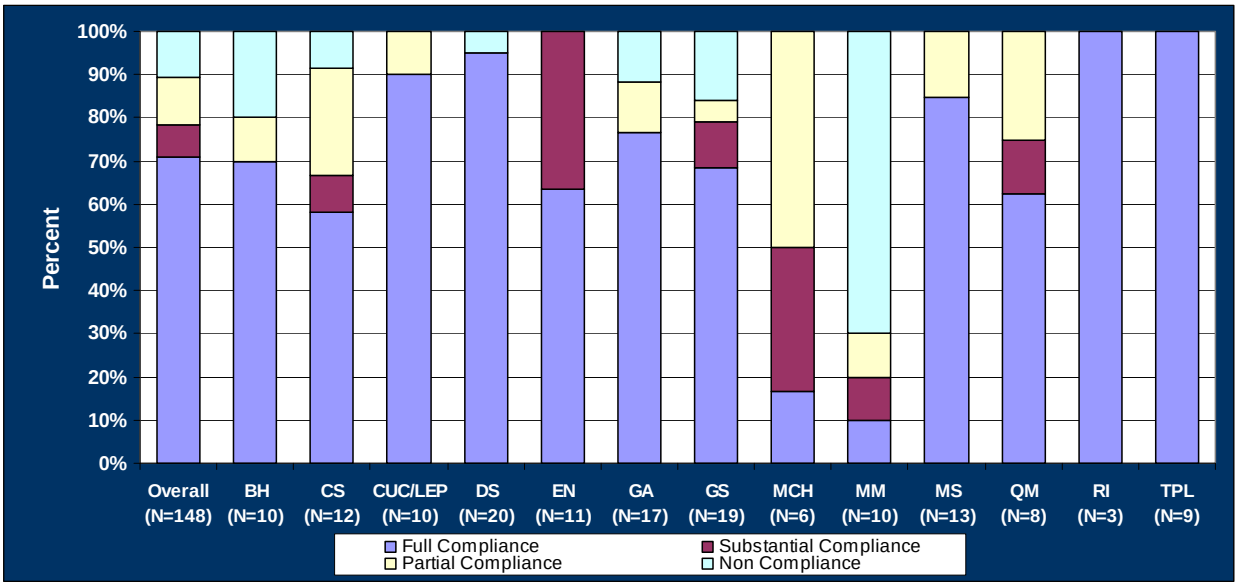


Figure 6-9 shows that DES/CMDP was in full compliance with 71 percent of the 148 reviewed standards (left-most bar), with considerable variation in performance across the categories. The percentage of each category in full compliance ranged from a low of 10 percent (Medical Management) to 100 percent (Reinsurance and Third Party Liability). In addition to the two categories in full compliance with 100 percent of the review standards, the Cultural Competency/Limited English Proficiency, Delivery System, and Member Services categories were assessed as having at least 85 percent of the reviewed standards in full compliance. Following the Medical Management category (10 percent in full compliance), the Maternal/Child Health category represented the area with the next-greatest opportunity for improvement (17 percent).

[6-14] The category names were abbreviated as follows: BH=Behavioral Health, CS=Claim Systems, CUC/LEP=Cultural Competency/Limited English Proficiency, DS=Delivery System, EN=Encounters, GA=General Administration, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, MS=Member Services, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

CAPs

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop, submit to AHCCCS for review and approval, and implement a CAP. Table 6-17 presents the number and proportion of CAPs required within and across the categories for the compliance standards reviewed for CYE 2007.

Table 6-17—Corrective Action Plans By Category *for* DES/CMDP

Category	Number of CAPs	% of Total CAPs	Total # of Standards	CAPs as % of the Category
Behavioral Health	3	7%	10	30%
Claim Systems	5	12%	12	42%
Cultural Competency/Limited English Proficiency	1	2%	10	10%
Delivery System	1	2%	20	5%
Encounters	4	9%	11	36%
General Administration/Corporate Compliance	4	9%	17	24%
Authorization and Denial/Grievance System	6	14%	19	32%
Maternal/Child Health	5	12%	6	83%
Medical Management	9	21%	10	90%
Member Services	2	5%	13	15%
Quality Management	3	7%	8	38%
Reinsurance	0	0%	3	0%
Third Party Liability	0	0%	9	0%
Overall	**43**	**100%**	**148**	**29%**

Note: The overall percent of total CAPs may not sum up to 100 percent due to rounding.

Table 6-17 shows that the Medical Management category had the largest proportion of CAPs, with 21 percent (9 of 43) of the required CAPs, followed by the Authorization and Denial/Grievance System, Claim Systems, and Maternal/Child Health categories (14 percent, 12 percent, and 12 percent, respectively). Notably, two categories did not require any CAPs (Reinsurance and Third Party Liability), and only one CAP was required for the Cultural Competency/Limited English Proficiency and Delivery System categories. Based on the proportion of standards requiring a CAP within a category, the Medical Management category exhibited the greatest opportunity for improvement since 90 percent of the reviewed standards required a CAP. This category was followed by the Maternal/Child Health, Claim Systems, Quality Management, and Encounters categories, for which more than one-third of the reviewed standards required CAPs (83 percent, 42 percent, 38 percent, and 36 percent, respectively). Overall, 43 of the 148 reviewed standards (29 percent) required a CAP in CYE 2007.

Table 6-18 presents a two-year comparison of required CAPs for overlapping categories of review. While the numbers of required CAPs in each category cannot be directly compared due to differences in the number of standards reviewed by AHCCCS, the percentage of CAPs within each category can be compared from year to year.

Table 6-18—2-Year CAP Overview *for* DES/CMDP						
	CYE 2006			CYE 2007		
Category	Total Number of Standards	Number of CAPs	% of Category Standards	Total Number of Standards	Number of CAPs	% of Category Standards
Claim Systems	14	6	43%	12	5	42%
Delivery System	7	1	14%	20	1	5%
Authorization and Denial/Grievance System	22	5	23%	19	6	32%
Maternal/Child Health	7	1	14%	6	5	83%
Medical Management	5	0	0%	10	9	90%
Quality Management	2	2	100%	8	3	38%
Reinsurance	3	3	100%	3	0	0%
Third Party Liability	9	1	11%	9	0	0%
Overall	**69**	**19**	**28%**	**87**	**29**	**33%**

Overall, Table 6-18 indicates that DES/CMDP's performance decreased from CYE 2006 (28 percent) to CYE 2007 (33 percent), although the difference was not statistically significant (p=.436). Among the eight overlapping categories, DES/CMDP was able to resolve all of the required CYE 2006 CAPs for the Reinsurance and Third Party Liability categories. Each of these categories had at least one CAP in CYE 2006, but no CAPs were required in CYE 2007. The Delivery System and Quality Management[6-15] categories also demonstrated improvement based on the relative decrease in the percentage of required CAPs since CYE 2006 (a 64 percent decrease and 62 percent decrease, respectively). However, Table 6-18 also highlighted some opportunities for improvement based on the proportional increase in the required CAPs for the Authorization and Denial/Grievance System (a 39 percent increase), Maternal/Child Health (a 493 percent increase), and Medical Management (from zero to nine required CAPs) categories.

Strengths

All of the reviewed standards within the Reinsurance and Third Party Liability categories were assessed as being in full compliance with AHCCCS's technical standards. These areas were recognized strengths for DES/CMDP. Additional strengths were identified within the Delivery System and Quality Management categories based on the large improvement noted between CYE 2006 and CYE 2007.

[6-15] The results for the category show a relative improvement along with the number of CAPs increasing from 2 to 3 CAPs. This result is due to the relatively large increase in the number of standards reviewed in the current review cycle compared with the previous review (from 3 to 10 reviewed standards).

Opportunities for Improvement and Recommendations

In the final report generated from DES/CMDP's OFR, AHCCCS included a detailed list of recommendations at both the standard and the category levels. A review of these recommendations highlights two key themes that underlie several opportunities for improvement across multiple categories, including effectively monitoring the Contractor's clinical and nonclinical programs and ensuring complete and accurate documentation of policies and procedures. For example, AHCCCS recommended that DES/CMDP improve its monitoring of activities such as PCP compliance with behavioral health timeliness and documentation standards (Behavioral Health), postprocessing and auto-adjudication of claims and subsequent trending of encounter quality measures (Claim Systems and Encounters), provider network compliance with appointment availability and wait-time standards (Delivery System), grievance and appeal processes (Authorization and Denial/Grievance System), and the effectiveness of its compliance program (General Administration/Corporate Compliance). Additionally, deficiencies in monitoring member utilization and provider quality programs were also noted in several areas (Quality Management, Medical Management, and Maternal/Child Health). Together, these recommendations highlight the importance of establishing a comprehensive strategy for monitoring performance across all operational areas. It is strongly recommended that DES/CMDP evaluate both current committee structures and internal quality improvement processes to ensure that quality improvement activities are continuous and built upon results obtained from ongoing monitoring efforts.

AHCCCS also recommended that DES/CMDP enhance current policies, procedures, and notifications/letters for informing members and providers of member rights regarding authorizations and the grievance process (Authorization and Denial/Grievance Systems), as well as refine policies regarding new technologies and emergency department notifications (Medical Management and Authorization). These recommendations highlight the need for DES/CMDP to evaluate its current policymaking processes and ensure that all written policies and letters for communicating with members address AHCCCS requirements. Additionally, DES/CMDP should ensure that all documents for providers and members are written in commonly understood language. Establishing a strategy for developing comprehensive, clear, and concise policies in all operational areas should ensure that written documents address all applicable AHCCCS requirements, guide DES/CMDP's compliance with AHCCCS's standards, and lead to more efficient operations.

HSAG's review supports these recommendations and includes the following additional recommendations for areas with the greatest opportunities for improvement: Claim Systems, Encounters, Authorization and Denial/Grievance System, Maternal/Child Health, Medical Management, and Quality Management.

- **Claim Systems:** Overall, 42 percent (5 out of 12 standards) of the reviewed standards in CYE 2007 required a CAP, suggesting considerable opportunity for improvement in DES/CMDP's performance. As AHCCCS noted in its review, DES/CMDP experienced multiple challenges throughout the year in meeting the required claims processing rates. However, recent corrective action helped return the Contractor to compliance. In general, the five required CAPs highlight deficiencies in DES/CMDP's monitoring of its claims system (postprocessing and auto-adjudication audits), documentation of its analysis and subsequent interventions associated with claim disputes, payment of interest on late-paid claims, and the inability to accept electronic

claim submissions. These findings indicate an overarching need to enhance DES/CMDP's monitoring of, and system capabilities for, processing claims.

To address these CAPs, it is recommended that the Contractor implement and formalize an analytic program of activities designed to monitor the quality and integrity of its claims system. The tracking and trending of data should be based on sound scientific methods and ensure the timely notification of abnormal trends in data. Moreover, the Contractor should conduct a review of its current operational systems and resources to identify an efficient method by which it can begin accepting electronic claims from its providers. The full integration of electronic claims will assist in monitoring and ensuring quality/completeness of the claims. Additionally, the Contractor should cross-reference its current policies and procedures with AHCCCS's requirements to ensure that they address all applicable AHCCCS standards. Where discrepancies are noted, the Contractor should take immediate steps to revise and reapprove/reissue policies. Finally, DES/CMDP should evaluate the gains that could be achieved by implementing an organizationwide push to increase documentation of the actions it has taken and improvement interventions it has implemented as one way to demonstrate its performance in complying with AHCCCS standards.

- **Encounters:** More than one-third (36 percent) of the reviewed standards in the Encounters category required a CAP in CYE 2007. Specifically, 4 out of 11 standards were assessed as in substantial compliance. In general, the findings from this review highlighted the need for DES/CMDP to evaluate, revise, and continue to monitor compliance with many of the standards in this category. However, moderate compliance levels (i.e., 80–85 percent) for these indicators appeared to be attributed to outlier data during measurement periods and not necessarily to system-based issues with the Contractor's ability to track and audit adjudicated, denied, deleted, and pended encounters. Further, more recent data trends show that the Contractor's compliance level was generally improving. AHCCCS is currently implementing system upgrades to aid Contractors in data submission and approval and has scheduled meetings to provide additional technical assistance to address the timeliness issues. It is recommended that the Contractor participate in AHCCCS initiatives and make related system adjustments to ensure the timely, accurate, and complete submission of encounter data. Additionally, if submission problems continue, it is recommended that DES/CMDP conduct a root-cause analysis to evaluate internal data system issues that could be affecting the submission of its data.
- **Authorization and Denial/Grievance Systems:** Slightly less than one-third (32 percent) of the reviewed standards in this category (6 out of 19 standards) required a CAP in CYE 2007. Of these standards, five of the six required CAPs were within the first six standards. These standards highlighted opportunities for improvement in monitoring the quality and timeliness of prior-authorization decisions and notifications, as well as the need to modify emergency room notifications to comply with AHCCCS and BBA requirements. Additionally, a CAP was required to amend the Notice of Decisions to include appropriate legal citations. These findings outline an important opportunity to improve an aspect of health care that is central to member health and member/provider satisfaction. Service authorization activities and communications with members and providers should be grounded in clear and concise policies and procedures that include adequate monitoring to ensure procedural compliance with AHCCCS requirements.

  To address these deficiencies, DES/CMDP should convene an internal work group to cross-reference current policies and procedures with AHCCCS's requirements. When discrepancies or the need for clarification are identified, DES/CMDP should take corrective actions to revise the documents and bring them into alignment with AHCCCS standards. Additionally, DES/CMDP

should review its current notification process flow related to the authorization and denial/grievance system and identify points where additional monitoring can be implemented to ensure all timeliness standards are met and documented. DES/CMDP should identify current tracking systems that might be enhanced to include electronic tracking of the receipt, decisions, and submission of authorization requests and decision notifications. The development of an organizationwide culture of timely, accurate, and complete documentation is one important and effective strategy for implementing change in performance results.

- **Maternal/Child Health:** Overall, 83 percent of the standards reviewed in CYE 2007 (five out of six standards) required a CAP. This category exhibited the greatest opportunity for improvement for DES/CMDP. In general, AHCCCS's review indicated that while DES/CMDP had an effective case management process in place to ensure that members with high-risk pregnancies received needed care and services, the Contractor did not have an effective system to monitor its maternity outreach programs, including prenatal and postpartum visits or provider compliance with notifying members of their family planning rights. Additionally, one CAP was related to DES/CMDP monitoring and evaluating provider use of the PEDS tool.

  To address these CAPs, it is recommended that the Contractor convene a time-limited work group to identify and recommend effective methods and measures for tracking and evaluating the effectiveness of DES/CMDP's maternity outreach programs. The work group should also conduct a root-cause analysis to identify current barriers affecting women's entry into and use of ongoing prenatal and postpartum care. Once barriers are identified, the work group should work with existing committees and providers to design, implement, and monitor appropriate improvement interventions. Additionally, DES/CMDP may want to use this work group to develop effective strategies for monitoring providers' documentation that they informed at-risk members of the availability of family planning services. By developing a comprehensive strategy for monitoring and oversight of the maternal/child health program, DES/CMDP will generate increased information upon which continuous quality improvement can be established. A comprehensive strategy will also enhance DES/CMDP's ability to effectively coordinate care for this high-risk population.

- **Medical Management:** With 90 percent of the reviewed standards (9 out of 10 standards) requiring a CAP, the entire category of Medical Management is an opportunity for improvement for DES/CMDP. Identified opportunities for improvement included: designing and implementing comprehensive monitoring programs for reviewing and reporting member/provider utilization, concurrent review, emergency room utilization, disease management outcomes and utilization, and timeliness of authorizations; tracking catastrophic and reinsurance members; increasing effectiveness of care coordination and case management for members with special health care needs; and revising/strengthening the detail and comprehensiveness of its policies and procedures related to emergency services and to the evaluation of new technologies. DES/CMDP's required CAPs also highlighted the need for increased documentation in meeting minutes of the Medical Management Committee's review of monitoring reports/results and actions recommended/taken by the committee.

  To address these issues, it is recommended that DES/CMDP form an interdepartmental work group to evaluate the current structure of its medical management program. In addition to designing and implementing a comprehensive monitoring program, the work group should also identify ways to incorporate scientific rigor into its medical management activities, including the development of measures and reporting processes to provide DES/CMDP staff with sufficient information to design effective interventions and to coordinate needed care for members.

Additionally, industry standards for measuring disease management outcomes should be incorporated into ongoing monitoring programs, including those related to member utilization and member/provider profiles. Implementing these monitoring and reporting strategies should bring DES/CMDP into greater compliance with AHCCCS standards and contribute to its ability to deliver effective care to its members.

It is also recommended that the work group review DES/CMDP's medical management policies and procedures. Specifically, each policy should be crosswalked to the associated AHCCCS standard to ensure all mandatory language and processes are clearly and concisely documented. In many cases, DES/CMDP would benefit from simply enhancing current policies by making them more detailed and comprehensive. Finally, DES/CMDP should consider modifying the Medical Management Committee meeting structure and activities to facilitate complete documentation of activities conducted and decisions made by this group. This could include developing a standardized form for organizing, tracking, and documenting committee discussions and decisions.

- **Quality Management:** Overall, more than one-third (38 percent) of the standards in this category (three out of eight standards) required a CAP in CYE 2007. The required CAPs for this category were to address deficiencies in two primary areas: (1) improving the quality and detail of documentation contained in abuse/complaint case records and ensuring monitoring of appropriate resolutions and (2) continuing CAPs for those measures that remained below the AHCCCS MPS.

  To resolve these CAPs, DES/CMDP's QM/PI Committee should review the quality of its current documentation. Based on its review, the committee should redefine the expectations for acceptable levels of documentation and ensure that documentation requirements and procedures are in alignment with AHCCCS requirements. Additionally, the committee should consider establishing operational policies and procedures to formalize its documentation requirements and processes, including the development/use of standardized forms and best practices, and communicate them to all staff. It is also recommended that DES/CMDP establish an internal work group to evaluate its current processes for collecting, reporting, and evaluating the progress of interventions and quality improvement activities based on performance measure results. The work group should focus on identifying effective mechanisms for integrating the use of evaluation results into a continuous quality improvement process. Moreover, these processes should be formalized and identified as a key function of DES/CMDP's QM/PI Committee.

Summary

In general, DES/CMDP's compliance with AHCCCS's operational and financial standards somewhat declined in CYE 2007, although the difference was not statistically significant (p=.024). Additionally, while some individual categories (i.e., Cultural Competency/Limited English Proficiency, Delivery System, Reinsurance, and Third Party Liability) exhibited a high percentage of standards in full compliance, several opportunities for improvement were observed for others (i.e., Claim Systems, Encounters, Authorization and Denial/Grievance System, Maternal/Child Health, Medical Management, and Quality Management). Notably, all the standards within the Reinsurance and Third Party Liability categories were assessed to be in full compliance and were recognized as strengths for DES/CMDP.

Comparative Results for Acute Care and DES/CMDP Contractors

The following section presents a comparative analysis of the performance results from AHCCCS's OFR for Acute Care and DES/CMDP Contractors. Findings are provided on the proportion of each Contractor's compliance standards assessed in full compliance, substantial compliance, partial compliance, and noncompliance. Additionally, a comparison of the percentage of reviewed compliance standards requiring a CAP is also presented for each Acute Care and DES/CMDP Contractor.

Findings

Figure 6-10 shows the overall percentage of each Contractor's reviewed standards AHCCCS found to be in full compliance, substantial compliance, partial compliance, and noncompliance, with full compliance on the bottom of the stacked bars. The left-most bar in the figure shows the proportions for compliance categories across the nine Contractors.

Figure 6-10—Categorized Levels of Compliance With Technical Standards for Acute Care and DES/CMDP Contractors[6-16]

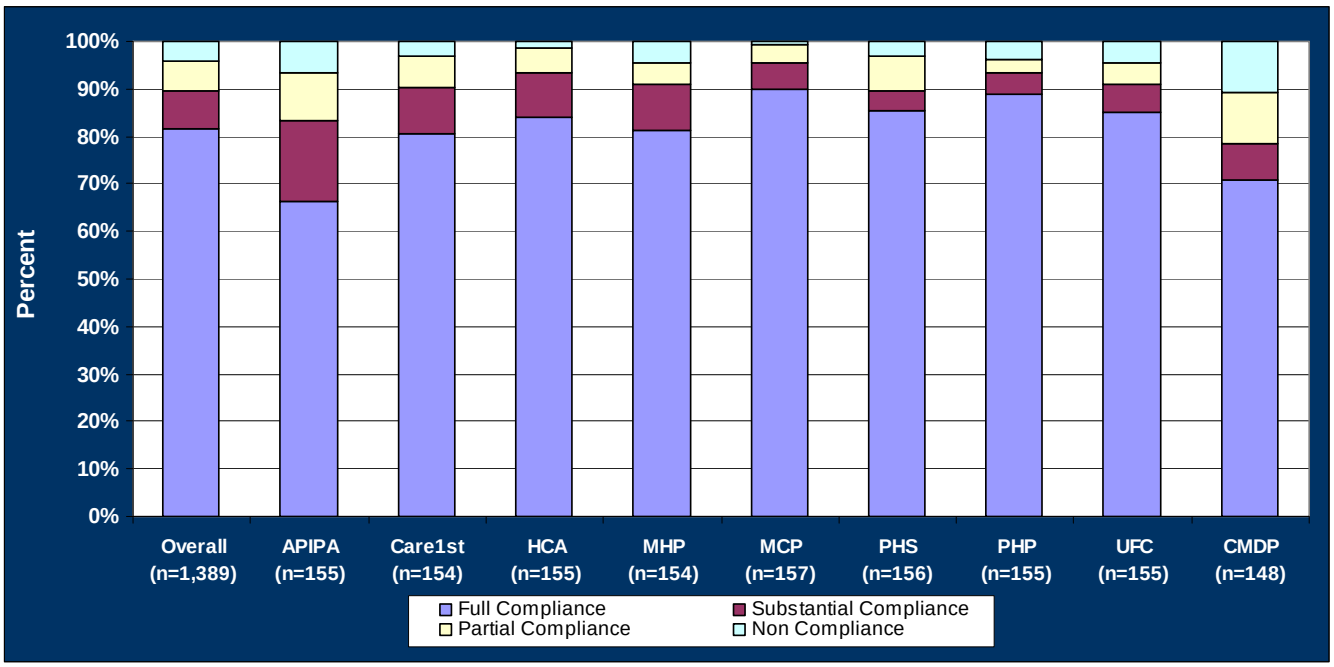


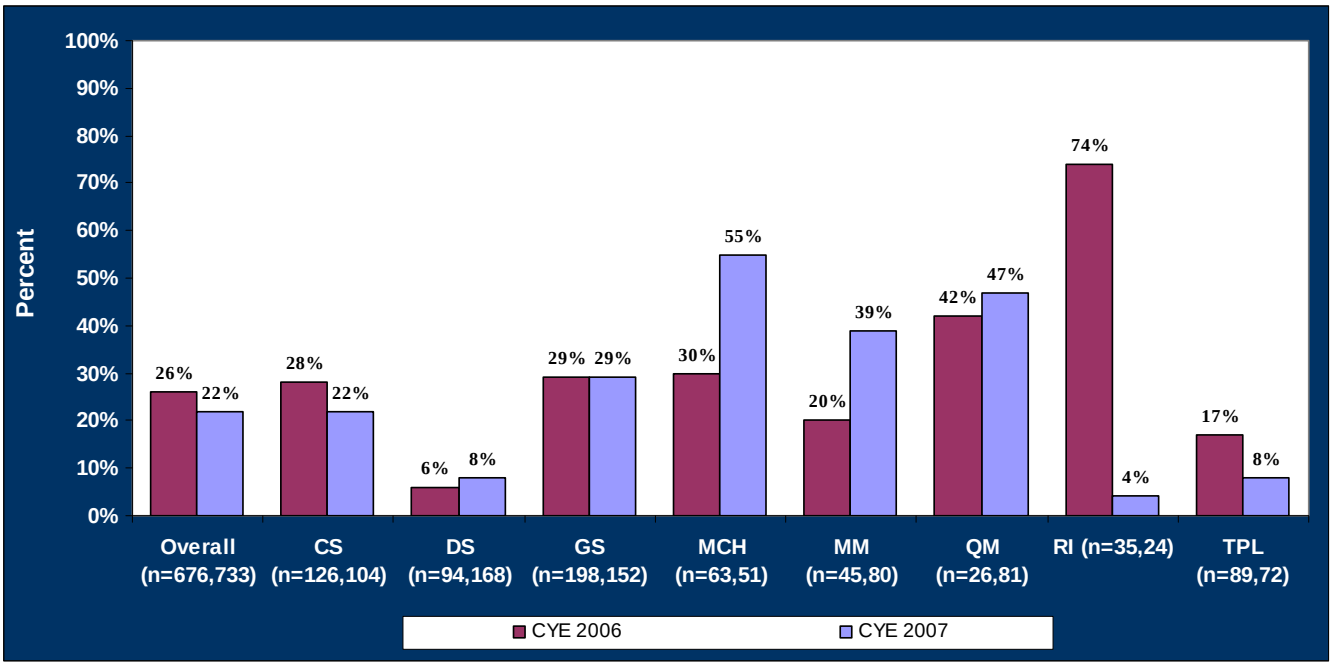
Figure 6-10 shows that 81 percent of all reviewed standards were in full compliance across the nine Acute Care and DES/CMDP Contractors. The percentage of standards in full compliance for each Contractor ranged from 66 percent (APIPA) to 90 percent (MCP). Two Contractors showed results that were substantively higher than the overall Contractors' average across all reviewed standards:

[6-16] The Contractors' names were abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health System, PHP=Phoenix Health Plan/Community Connections, UFC=University Family Care, and Department of Economic Security/Comprehensive Medical and Dental Program=DES/CMDP.

MCP (90 percent) and PHP (89 percent). Conversely, two of the other Contractors showed results that were substantively lower than the overall average: APIPA (66 percent) and DES/CMDP (71 percent). Of these two Contractors, DES/CMDP exhibited slightly lower performance as evidenced by a somewhat higher percentage of standards assessed in partial and noncompliance (22 percent) compared to APIPA (16 percent).

When AHCCCS scores performance for a standard as less than fully compliant, it requires the Contractor to develop a corrective action plan (CAP), submit it to AHCCCS for review and approval, then implement it. AHCCCS's review team may also require a CAP for a fully compliant standard when an aspect of the Contractor's performance for the standard should be enhanced.[6-17] This situation occurred 14 times among the Acute Care and DES/CMDP Contractors. With different numbers of required standards across Acute Care and DES/CMDP Contractors, and the presence of CAPs for some standards in full compliance, the most valid method for comparing results is through the percentage of reviewed standards that required a CAP. The overall proportion of standards across all Acute Care and DES/CMDP Contractors with a CAP and the proportion for each category are shown in Figure 6-11. The figure shows the eight categories that overlapped between the previous and the current review cycles.

Figure 6-11—Two-Year Comparison of the Percentage of Standards With a CAP for Acute Care and DES/CMDP Contractors[6-18]



Note: Parenthetical numbers represent the total number of standards reviewed in CYE 2006 (first number) and CYE 2007 (second number). Only those categories evaluated in both contract years are presented in this figure.

[6-17] Full compliance is noted when 90 to 100 percent of all required aspects of a standard are in compliance. Any portion of the standard not in compliance could still require a CAP.

[6-18] The category names were abbreviated as follows: CS=Claim Systems, DS=Delivery System, GS=Authorization and Denial/Grievance System, MCH=Maternal/Child Health, MM=Medical Management, QM=Quality Management, RI=Reinsurance, and TPL=Third Party Liability.

Overall, Figure 6-11 illustrates that improvement was seen for comparable categories of standards. The total percentage of standards that required a CAP decreased from 26 percent (CYE 2006) to 22 percent (CYE 2007). The 4 percent drop represents a 15 percent relative improvement, although it only approached statistical significance (p=.083). However, while this finding is suggestive of improvement across all Contractors, systemwide opportunities for improvement were noted since approximately one in every five reviewed standards required a CAP.

The greatest improvement was observed in the Reinsurance category. The percentage of CAPs required for the Reinsurance category, fell from 74 percent in CYE 2006 to just 4 percent in CYE 2007, a statistically significant difference (p<.001). This improvement demonstrates the extent of improvement that is possible within the span of a single review cycle. However, caution should be used when interpreting this result due to the comparatively small number of standards; there were only four standards in CYE 2006 and three standards in CYE 2007. Conversely, the largest increase in the number of required CAPs was noted in the Maternal/Child Health category. Based on the percentage of required CAPs, performance for this category significantly increased 25 percentage points from 30 percent in CYE 2006 to 55 percent in CYE 2007 (p=.008). The Medical Management category also exhibited a statistically significant increase (p=.031) of 19 percentage points between CYE 2006 and CYE 2007 (20 percent compared to 39 percent, respectively). Also, the number of required CAPs for the Quality Management category remained comparatively high (47 percent in CYE 2007). Due to changes in the number of standards reviewed (CYE 2006 = 26, CYE 2007 = 81), comparability in rates is somewhat limited.

A comparison of the CAPs across compliance categories and Acute Care and DES/CMDP Contractors highlights general areas for quality improvement. Table 6-19 presents the total number of CAPs required for each Acute Care and DES/CMDP Contractor and for each category of standards. However, due to differences in the number of standards reviewed for each Contractor, caution should be used when interpreting differences in the total number of CAPs.

Table 6-19—Number and Percentage of CAPs by Category and Acute Care and DES/CMDP Contractor1-[19]

Category	APIPA	Care1st	HCA	MHP	MCP	PHS	PHP	UFC	DES/ CMDP
Behavioral Health	1 (10%)	0 (0%)	2 (20%)	4 (40%)	2 (20%)	2 (20%)	6 (60%)	4 (40%)	3 (30%)
Claim Systems	3 (23%)	4 (31%)	1 (8%)	2 (15%)	2 (15%)	2 (15%)	0 (0%)	4 (31%)	5 (42%)
Cultural Competency/ Limited English Proficiency	6 (60%)	3 (30%)	1 (10%)	3 (30%)	1 (10%)	0 (0%)	0 (0%)	3 (30%)	1 (10%)
Delivery System	9 (43%)	1 (5%)	2 (10%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)
Encounters	2 (17%)	1 (9%)	3 (25%)	6 (55%)	1 (8%)	3 (25%)	0 (0%)	0 (0%)	4 (36%)
General Administration	5 (29%)	4 (24%)	2 (12%)	1 (6%)	0 (0%)	0 (0%)	1 (6%)	1 (6%)	4 (24%)
Authorization & Denial/Grievance System	7 (37%)	4 (21%)	2 (11%)	5 (26%)	5 (26%)	8 (42%)	2 (11%)	5 (26%)	6 (32%)
Maternal/Child Health	6 (100%)	4 (67%)	3 (50%)	3 (50%)	2 (29%)	1 (14%)	0 (0%)	4 (57%)	5 (83%)
Medical Management	5 (50%)	5 (50%)	1 (10%)	1 (10%)	0 (0%)	7 (70%)	2 (20%)	1 (10%)	9 (90%)
Member Services	0 (0%)	0 (0%)	1 (7%)	2 (13%)	1 (7%)	0 (0%)	0 (0%)	2 (13%)	2 (15%)
Quality Management	8 (15%)	5 (50%)	5 (50%)	4 (40%)	3 (27%)	1 (10%)	6 (60%)	3 (30%)	3 (38%)
Reinsurance	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	0 (0%)	0 (0%)	0 (0%)
Third Party Liability	1 (11%)	1 (11%)	2 (22%)	0 (0%)	0 (0%)	0 (0%)	2 (22%)	0 (0%)	0 (0%)
Total # CAPs (Total % CAPs)[A]	**53 (34%)**	**32 (21%)**	**25 (16%)**	**31 (20%)**	**17 (11%)**	**25 (16%)**	**19 (12%)**	**27 (17%)**	**43 (29%)**

[A] Comparisons between the total number of CAPs should be interpreted with caution due to differences in the number of standards associated with each Contractor. However, the total percentage of CAPs reflect for these differences and, therefore, can be compared across Acute Care and DES/CMDP Contractors.

Overall, Table 6-19 shows that the percentage of CAPs required during the current review period ranged from 11 percent (MCP) to 34 percent (APIPA). MCP exhibited the lowest percentage of CAPs (11 percent), followed by PHP (12 percent). Conversely, the Contractors showing the poorest performance (i.e., the highest percentage of CAPs) were APIPA (34 percent) and DES/CMDP (29 percent). These results highlight considerable variation across the Acute Care and DES/CMDP Contractors.

[1-19] The Contractors' names are abbreviated as follows: APIPA=Arizona Physicians IPA, Care1st=Care1st, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health System, PHP=Phoenix Health Plan/Community Connections, UFC=University Family Care, Arizona Department of Economic Security/Comprehensive Medical and Dental Plan=DES/CMDP.

Strengths

The results for the OFR illustrate considerably stronger performance for MCP and PHP. The results from AHCCCS's review suggest that these Contractors' operations were substantively more compliant than those evaluated for other Acute Care and DES/CMDP Contractors. In general, the Reinsurance and Third Party Liability categories were recognized as strengths based on the large proportional decreases in the number of CAPs required. Performance in the Delivery System category also indicated that this category was a relative strength for the Contractors, with 8 percent of the standards requiring CAPs across all Contractors.

Opportunities for Improvement and Recommendations

The greatest opportunities for improvement across the Acute Care and DES/CMDP Contractors were noted in the Maternal/Child Health and Medical Management categories. Both categories exhibited statistically significant declines in performance since the previous review period. Additionally, the overall percentage of required CAPs was comparatively high for the Quality Management category. At 47 percent, the Quality Management category was the second-highest category, next to the Maternal/Child Health category (55 percent), in the number of required CAPs. Each of these areas is discussed within the context of the Contractors having required CAPs and the standards for which the CAPs were required.

- **Maternal/Child Health:** Although all Acute Care and DES/CMDP Contractors were able to provide required services to pregnant women, five Contractors did not have effective systems in place to monitor maternity program outreach activities. The standards least in compliance were those related to coordination with the AzEIP; the implementation of the PEDS tool, including appropriate and accurate training for providers; and effective monitoring of referrals to family planning services to ensure all members have appropriate access to services. All of these areas represent opportunities for improvement. Contractors should establish multidisciplinary work groups to evaluate the operational policies and procedures surrounding their maternal and child health programs. Based on the findings of this review, Contractors should implement organizational and cultural changes to bring operations into alignment with AHCCCS requirements.
- **Medical Management:** In general, the poor performance by three Contractors had an overall negative impact on the percentage of standards that required a CAP in this category. One standard in particular presented an underlying problem for the Acute Care and DES/CMDP Contractions—i.e., "The Contractor has adopted and implemented a policy for the evaluation of new technologies that complies with AHCCCS standards." While policies were documented, they had not been operationalized or implemented in the Contractors' organizations, or they had not taken time-sensitive requests into consideration. The lack of full compliance with these standards may reflect few requests for new technologies instead of inactivity by the Contractors. Nonetheless, Contractors should evaluate their current operational processes and ensure that organizational activities support and complement AHCCCS standards.
- **Quality Management:** Underlying the lack of compliance in the Quality Management category was the unsuccessful translation of quality management research into viable interventions. This finding was reflected in the lack of quality management meeting minutes that documented discussions of current CAPs, proposed interventions, and timelines for implementation.

Additionally, standards related to ongoing organizational credentialing and the effective monitoring of interventions developed as a result of member complaint/abuse issues continue to represent opportunities for improvement among Contractors. It is recommended that Contractors evaluate the current structure of existing committees and implement changes that focus on using them to more effectively monitor, manage, and initiate improvement activities through increased accountability.

Summary

In general, the percentage of reviewed standards that required a CAP appeared to be decreasing (p=.083). While some compliance categories exhibited increases in the number of required CAPs, large proportional improvements were seen for several categories. For example, the Reinsurance category moved from having the highest percentage of CAPs in CYE 2006 (74 percent) to having only one CAP required in CYE 2007 (4 percent). This finding demonstrates the degree of change within a category that is possible within one reporting year and with focused, strategic improvement activities. However, caution should be used when interpreting this result due to the comparatively small population size (n=4). The intensity of effort and use of strategic interventions implemented to improve performance on the Reinsurance standards should be applied to improving Contractor performance for the Maternal/Child Health, Medical Management, and Quality Management categories, where opportunities for improvement continued to exist.

7. Performance Measure Performance

In accordance with 42 CFR 438.240(b), AHCCCS contractually requires Contractors to have a QAPI program that includes measuring and submitting data to AHCCCS on their performance. Validating MCO and PIHP performance measures is one of the three BBA mandatory external quality review activities described at 42 CFR 438.358(b)(2). The requirement at 438.358(a) allows states, its agents that are not an MCO or PIHP, or an EQRO to conduct the mandatory activities. Performance results can be reported to the state by the MCOs/PIHPs (as required by the state) or the state can calculate the MCOs'/PIHPs' performance on the measures for the preceding 12 months. Performance must be reported by the MCOs/PIHPs—or calculated by the state—and validated annually.

As permitted by 42 CFR 438.258(a), AHCCCS elected to conduct the functions associated with the BBA mandatory activity of validating performance measures. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1-5), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its performance measure calculation and its data validation activities to prepare this 2006–2007 annual report.

Conducting the Review

AHCCCS calculated and reported Contractor-specific and statewide-aggregate performance for the following AHCCCS-selected measures:

- Children's Access to Primary Care Practitioners (12–24 months, 25 months–6 years, 7–11 years, and 12–19 years)
- Adults' Access to Preventative/Ambulatory Health Services (20–44 years, and 45–64 years)*
- Well-Child Visits in the First 15 Months of Life*
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Annual Dental Visit
- EPSDT Participation

* Not required for DES/CMDP

Using AHCCCS's results and statistical analysis of Contractors' performance rates, HSAG organized, aggregated, and analyzed the performance data. From its analysis, HSAG was able to draw conclusions about Contractor-specific and statewide aggregate performance related to the quality and timeliness of, and access to, care and services Contractors provided to AHCCCS members.

Objectives for Conducting the Review

In its objectives to measure, report, compare, and continually improve Contractor performance AHCCCS conducted the following activities:

- Provided key information about AHCCCS-selected performance measures to each Contractor
- Used Contractor data AHCCCS collected to calculate the performance measure rates
- Performed encounter validation according to industry standards

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for the nine Acute Care and DES/CMDP Contractors' performance with respect to each of the AHCCCS-selected measures. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on each of the AHCCCS-selected measures.
- Compare Contractor performance to AHCCCS's MPS, goals, and long-range benchmarks for each measure.
- Provide data from analyzing the performance results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across the Contractors.
- Aggregate and assess the AHCCCS-required Contractor CAPs to provide an overall evaluation of performance for each Contractor and statewide across Contractors.

Methodology for Conducting the Review

For the review period of CYE 2007 (measurement year ending September 30, 2006), AHCCCS conducted the following activities:

- Collected Contractor encounter data associated with each of the State-selected measures
- Calculated, for each measure, Contractor-specific performance rates and statewide aggregate rates across all Contractors
- Performed encounter validation according to industry standards
- Reported Contractors' performance results by individual Contractor and in aggregate statewide
- Compared Contractor performance rates with standards defined by AHCCCS's contract
- Required Contractors to submit CAPs to AHCCCS for its review and approval when their performance did not meet AHCCCS's MPS for one or more measures

Contractor CAPs had to include an evaluation of the effectiveness of Contractors' current interventions and, when necessary, their plans to revise or replace them. AHCCCS required Contractors to include updates on the status and effectiveness of the CAPs in their annual Quality Management/Performance Improvement Plans and Evaluation, an AHCCCS-required contract deliverable.

AHCCCS calculated the rates to evaluate preventive health care quality following the HEDIS methodology. HEDIS, developed and maintained by the National Committee for Quality Assurance (NCQA), is a widely used and well accepted set of performance measures for health care providers.

To select the members included in the annual analysis, AHCCCS used HEDIS criteria (e.g., members must have been continuously enrolled with the Contractor for a specified minimum period of time). AHCCCS follows NCQA's methodology of rotating measurements to produce a more comprehensive annual report of preventive health care services over time without having to collect the entire measure set each year. This rotating schedule alternated measures on a biennial basis and made an intervention year possible for quality improvement efforts. It also gave each Contractor the opportunity to focus activities on improving specific measures that AHCCCS had identified in its prior-year annual reports as requiring corrective action to improve rates.

With few exceptions, AHCCCS used pure HEDIS specifications to calculate Contractor performance rates. For the EPSDT Participation measure, which was one of the exceptions, AHCCCS calculated the rate according to a methodology CMS developed for the EPSDT Form 416 report that state Medicaid agencies are required to submit annually to CMS. In addition to calculating and reporting rates for age stratifications as specified by HEDIS, AHCCCS also calculated and reported roll-up rates for two measures (i.e., Children's Access to Primary Care Practitioners and Adults' Access to Preventative/Ambulatory Health Services).

AHCCCS used administrative data collected from its automated managed care data system known as the Prepaid Medicaid Management Information System (PMMIS). AHCCCS selected members included in the denominator for each measure from the Recipient Subsystem of PMMIS. As a result, the numerators, and therefore the performance rates, are based on encounter data (records of services Contractors provided and the associated claims Contractors paid) in the PMMIS. The encounter data reported were based on Contractors' encounters for professional services, primarily physician clinic and office visits. Except for two of the measures (i.e., Adults' Access to Preventive/Ambulatory Health Services and Dental Visits), AHCCCS's methodology to collect the data differed only slightly from its previous methodology. The differences reflected enhanced coding to ensure that the data collection process conformed to HEDIS specifications. The coding changes resulted in slightly lower rates reported for some of the measures.

AHCCCS conducts annual validation studies of encounters. Based on the most recent validation study applicable to the data for this report, AHCCCS determined that:

- Approximately 90 percent of all encounters for Acute Care and DES/CMDP professional services were complete compared with the associated medical records.
- Approximately 85 percent of encounters were fully accurate compared with services documented in members' medical records.

Because AHCCCS calculated performance rates based on Contractor-submitted encounters, AHCCCS noted that rates may have been negatively affected if Contractors did not complete and submit all encounters for services provided that were applicable and could have been included in the calculations for performance for a given measure.

Using the performance rates and statistical analysis AHCCCS calculated for each Contractor, HSAG organized, aggregated, and analyzed the data in order to draw conclusions about Contractor performance in providing accessible, timely, and quality care and services to AHCCCS members. AHCCCS analyzed contractor-specific and statewide-aggregate performance results for each measure to determine:

- If Contractor performance rates met or exceeded AHCCCS's MPS, goals, or long-range benchmarks.
- The direction of any change in rates from previous measurement periods (if applicable) and whether the change was statistically significant.
- If a CAP was required.

AHCCCS required Contractors to submit a CAP to improve their performance on a measure when their performance rates did not achieve the AHCCCS MPS.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide-aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance rates.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results across the Contractors.

Contractor-Specific Results

AHCCCS calculated and provided to HSAG Contractor performance rates for the CYE 2007 AHCCCS-selected performance measures for each of the nine Acute Care and DES/CMDP Contractors. The nine Contractors include APIPA, Care1st, HCA, MHP, MCP, PHS, PHP, UFC, and DES/CMDP. The five measures reported in CYE 2007 were also reported in CYE 2006; however, AHCCCS modified the required MPS and goals for two of these measures (i.e., Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services). Specifically, Contractors are now responsible for performance on these two measures at the age-group level instead of just at the aggregated totals. Additionally, except for the Well-Child Visits—First 15 Months measure, all MPSs and goals were increased by AHCCCS in order to drive improvement in Contractor rates.

The CYE 2007 performance measures were:

- Children's Access to PCPs
  - 12–24 Months
  - 25 Months–6 Years
  - 7–11 Years
  - 12–19 Years
- Adults' Access to Preventive/Ambulatory Health Services
  - 20–44 Years
  - 45–64 Years
- Well-Child Visits—First 15 Months
- Well-Child Visits—3, 4, 5, 6 Years
- Adolescent Well-Care Visits
- Annual Dental Visit
- EPSDT Participation

The results for each Contractor are presented next, followed by comparative results across Contractors.

Arizona Physicians IPA, Inc.

APIPA serves eligible, enrolled members in all geographic service areas (GSAs) except for GSA 8 (Pinal and Gila counties), and has contracted with AHCCCS since 1982. At the time of this review, the Contractor had approximately 270,930 members.

Findings

Table 7-1 presents the performance measure rates for APIPA. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-1—Performance Measurement Review *for* APIPA

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	78.0%	**75.4%**	**-3.3%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	84.2%	**80.8%**	**-4.0%**	**p<.001**	85%	86%	97%
25 Months–6 Years	76.2%	**74.5%**	**-2.3%**	**p<.001**	78%	80%	97%
7–11 Years	77.2%	**74.3%**	**-3.7%**	**p<.001**	77%	79%	97%
12–19 Years	79.3%	**76.1%**	**-4.0%**	**p<.001**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	80.4%	**81.1%**	**0.9%**	**p=.012**	N/A[B]	N/A[B]	N/A[B]
20–44 Years	78.3%	78.8%	0.6%	p=.224	78%	80%	96%
45–64 Years	85.1%	**86.0%**	**1.0%**	**p=.043**	83%	84%	96%
Well-Child Visits—First 15 Months	51.8%	52.9%	2.2%	p=.342	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	57.9%	**56.0%**	**-3.4%**	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	33.4%	32.8%	-1.8%	p=.129	37%	38%	50%
Annual Dental Visit	57.9%	**59.6%**	**2.9%**	**p<.001**	51%	57%	57%
EPSDT Participation	69.4%	**65.9%**	**-5.0%**	**p<.001**	68%	69%	80%

A Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the p-value is ≤ .05. Rates in bold indicate statistical significance.

B During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Access to Preventative/Ambulatory Health Services measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-1 highlights considerable opportunities for improvement for APIPA. Of the 11 measures with an AHCCCS MPS in CYE 2007, only 4 (36.4 percent) met or exceeded the required MPS. Two of the four measures were the age-specific rates for the Adults' Access to

Preventive/Ambulatory Health Services measure. The rates for adults 20 to 44 years of age (78.8 percent) and 45 to 64 years of age (86.0 percent) both increased and exceeded the MPS of 78 percent and 83 percent, respectively. Additionally, the increase in rates for adults 45 to 64 years of age was statistically significant. The rate for the Annual Dental Visit measure also increased significantly from 57.9 percent in CYE 2006 to 59.6 percent in CYE 2007. APIPA's reported rate for this measure also exceeded AHCCCS's goal and long-range benchmark (both 57 percent). Finally, while APIPA's rate for the Well-Child Visits—3, 4, 5, 6 Years measure continued to meet AHCCCS's MPS, the rate significantly decreased 3.4 percent to 56.0 percent in CYE 2007.

Overall, from a continuous quality improvement perspective, performance for only 5 of the 13 measures (38.5 percent) demonstrated improvement between the two measurement periods. In total, rates for 8 of the 13 measures (61.5 percent) exhibited declines, 7 of which were statistically significant ($p \leq .05$). However, none of the relative changes in performance rates dropped more than 5 percent.

CAPs

APIPA was required to complete seven CAPs for the 11 performance measures reported in CYE 2007. This number represented 63.6 percent of the measures and included all Children's Access to PCPs age-group measures and the Well-Child Visits—First 15 Months, Adolescent Well-Care Visits, and EPSDT Participation measures. Each of these CAPs correlated with the access domain of care and indicated that APIPA's members were not receiving these services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks.

Strengths

The results for APIPA's Adults' Access to Preventive/Ambulatory Health Services measure clearly show this activity to be a strength for APIPA. All three of the rates associated with this measure exceeded AHCCCS's MPS. Moreover, the rate for members 45 to 64 years of age (86.0 percent) in CYE 2007 increased significantly and exceeded the AHCCCS goal of 84 percent. Additionally, APIPA's rate for the Annual Dental Visit measure (59.6 percent) continued to exceed AHCCCS's long-range benchmark of 57 percent. Both measures are a recognized strength for APIPA.

Opportunities for Improvement and Recommendations

The seven required CAPs for APIPA represent a clear opportunity for improvement since performance for each of these performance measures failed to meet AHCCCS's MPSs. These measures included all Children's Access to PCPs age-group measures and the Well-Child Visits—First 15 Months, Adolescent Well-Care Visits, and EPSDT Participation measures. The measures assess performance with respect to access, timeliness, and quality of care. It is recommended that APIPA conduct a causal/barrier analysis to evaluate the relationship between structural access, timeliness, and quality parameters and the performance measures requiring a CAP. Based on the findings of its internal review, APIPA should use rapid-cycle methodologies to operationalize and monitor the effectiveness of additional targeted improvement activities.

In general, improving the rates for access-based measures such as Children's Access to PCPs and Adolescent Well-Care Visits can be more difficult than for other measures since they require action

on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should consider enhancing current reminder systems or institute new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. Additionally, the Contractor should use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can be achieved by extending service hours, contracting with additional providers, and/or providing enhanced transportation options. Each of these interventions make it easier and more convenient for members to receive preventive services and visits. Both types of interventions should work to improve the overall rate of preventive visits received by children and adolescents.

It is also recommended that APIPA evaluate the interventions currently in place to improve the Adults' Access to Preventive/Ambulatory Health Services and Annual Dental Visit measures. Since these performance measures are a recognized strength for APIPA, lessons learned from quality improvement activities may be useful in improving the rates for other child and adolescent measures.

Summary

With a few exceptions (Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—3, 4, 5, and 6 Years, and Annual Dental Visits), the entire performance measures domain represents an opportunity for APIPA to improve its performance. Since most changes in the reported rates were negative and statistically significant, the current review does not indicate improvement. Instead, the results suggest high-priority opportunities for improvement. Current results indicate that approximately two-thirds (63.6 percent) of the Contractor's rates are below the standards set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the organizations.

Care1st Health Plan

Care1st serves eligible, enrolled members in GSA 12 (Maricopa County) and has contracted with AHCCCS since 2003. At the time of this review, the Contractor had approximately 27,900 members.

Findings

Table 7-2 presents the performance measure rates for Care1st. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-2—Performance Measurement Review *for* Care1st

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	77.7%	**69.5%**	**-10.6%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	88.8%	**80.4%**	**-9.5%**	**p<.001**	85%	86%	97%
25 Months–6 Years	73.6%	**67.2%**	**-8.7%**	**p<.001**	78%	80%	97%
7–11 Years	70.8%	66.4%	-6.2%	p=.079	77%	79%	97%
12–19 Years	71.9%	68.8%	-4.3%	p=.186	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	73.5%	75.6%	2.9%	p=.052	N/A[B]	N/A[B]	N/A[B]
20–44 Years	72.1%	74.0%	2.6%	p=.154	78%	80%	96%
45–64 Years	76.9%	79.5%	3.4%	p=.181	83%	84%	96%
Well-Child Visits—First 15 Months	59.1%	64.4%	9.0%	p=.074	70%	72%	90%
Well-Child Visits—3,4,5,6 Years	51.9%	51.6%	-0.5%	p=.875	56%	58%	80%
Adolescent Well-Care Visits	27.9%	29.7%	6.2%	p=.212	37%	38%	50%
Annual Dental Visit	51.3%	**54.1%**	**5.4%**	**p=.004**	51%	57%	57%
EPSDT Participation	68.2%	68.5%	0.5%	p=.520	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using AHCCCS's CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-2 highlights considerable opportunities for improvement for Care1st. Of the 11 measures with an MPS in CYE 2007, only 2 (18.2 percent) met or exceeded AHCCCS's required MPS. The rate for the Annual Dental visit measure significantly increased from 51.3 percent in CYE 2006 to 54.1 percent in CYE 2007 (p=.004), and exceeded the MPS of 51 percent. This change represented

a relative increase of 5.4 percent. The rate for the EPSDT Participation measure also increased in CYE 2007 (from 68.2 percent 68.5 percent), although this difference was not statistically significant (p=.520).

Additionally, the rates for several other measures (i.e., Adolescent Well-Care Visits, Well-Child Visits—3, 4, 5, and 6 Years, Well-Child Visits—First 15 Months, Adults' Access to Preventive/Ambulatory Health Services) remained statistically flat. Of note is the 9 percent relative change highlighted by the increase in the Well-Child Visits—First 15 Months measure. This increase approached statistical significance (p=.074) and is somewhat suggestive of overall improvement. The remaining measure, Children's Access to PCPs, exhibited substantive and statistically significant declines. The aggregate rate decreased by 10.6 percent between CYE 2006 (77.7 percent) and CYE 2007 (69.5 percent), which was a statistically significant decrease. In addition, rates for two age groups associated with this measure decreased by statistically significant amounts (12–24 Months and 25 Months–6 Years).

Overall, from a continuous quality improvement perspective, only 7 of the 13 measures (53.8 percent) indicated improvement between the two measurement periods. Of these seven measures, only one measure (Annual Dental Visit) showed a statistically significant gain (p=.004). Additionally, 6 of 13 measures (46.2 percent) exhibited declines, 3 of which were statistically significant ($p \leq .05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was 9.0 percent for Well-Child Visits—First 15 Months, while the maximum relative decline was 10.6 percent for Children's Access to PCPs (overall).

CAPs

Care1st was required to complete nine CAPs for the 11 performance measures reported in CYE 2007. This number represented 81.8 percent of the measures and included all measures except for Annual Dental Visit and EPSDT Participation. Each of these CAPs correlate highly with the aspect of care related to access and indicated that Care1st members were not receiving the associated services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. Additionally, the large number of CAPs required for Care1st suggests Contractor-wide opportunities for improvement.

Strengths

The results from Table 7-2 indicate that the Annual Dental Visit and EPSDT Participation measures were a recognized strength for Care1st as both CYE 2007 rates (54.1 and 68.5 percent, respectively) exceeded the AHCCCS MPSs. Additionally, the increase in the Annual Dental Visit rate between the two most recent measurement periods was statistically significant (p=.004). None of the other performance measures' rates reached AHCCCS's associated MPS.

Opportunities for Improvement and Recommendations

The nine required CAPs for Care1st represent a clear opportunity for improvement since rates for each of these performance measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, and Adolescent Well-Care Visits

measures. It is recommended that Care1st conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with the timeliness of care. Based on the findings of its internal review, Care1st should use rapid-cycle methodologies to operationalize and monitor the effectiveness of carefully selected and targeted interventions.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, and Adolescent Well-Care Visits can be more difficult than for other measures since it requires action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished through the implementation of a combination of interventions. For example, the Contractor should consider enhancing current reminder systems or add new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. Additionally, the Contractor should use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can often be achieved by extending physician office hours, contracting with additional providers, and/or providing enhanced transportation options for members. Each of these interventions make it easier and more convenient for members to receive preventive services and visits. These or other Contractor-identified interventions should have the desired effect of improving the overall rate of preventive visits received by children and adolescents. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

It is also recommended that Care1st evaluate the interventions currently in place to improve the Annual Dental Visit and EPSDT Participation measures. Since these performance measures are a recognized strength for Care1st, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

With a few exceptions (Annual Dental Visits and EPSDT Participation), the entire performance measures domain represents an opportunity for improvement. Current results indicate that 9 out of 11 (81.2 percent) of the Contractor's rates were below the MPS set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the organization. Since most reported rates remained statistically unchanged, the current review does not indicate improvement. Instead, the results suggest considerable opportunities for improvement.

Health Choice Arizona

HCA serves eligible, enrolled members in GSAs 4, 8, 10, and 12, which includes the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, and Pinal. The Contractor has contracted with AHCCCS since 1990 and had approximately 110,350 members at the time of this review.

Findings

Table 7-3 presents the performance measure rates for HCA. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-3—Performance Measurement Review *for* HCA

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	76.9%	**73.6%**	**-4.3%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	83.9%	**80.5%**	**-4.0%**	**p=.001**	85%	86%	97%
25 Months–6 Years	76.2%	**72.7%**	**-4.6%**	**p<.001**	78%	80%	97%
7–11 Years	74.1%	**71.9%**	**-3.0%**	**p=.012**	77%	79%	97%
12–19 Years	77.2%	**73.6%**	**-4.6%**	**p<.001**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	77.9%	77.4%	-0.7%	p=.338	N/A[B]	N/A[B]	N/A[B]
20–44 Years	77.0%	75.9%	-1.3%	p=.120	78%	80%	96%
45–64 Years	80.3%	80.6%	0.5%	p=.680	83%	84%	96%
Well-Child Visits—First 15 Months	49.4%	**59.3%**	**20.1%**	**p<.001**	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	59.5%	55.6%	-6.5%	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	32.6%	**31.1%**	**-4.8%**	**p=.024**	37%	38%	50%
Annual Dental Visit	55.2%	56.0%	1.3%	p=.107	51%	57%	57%
EPSDT Participation	70.0%	**61.7%**	**-11.9%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2007.

Using AHCCCS's CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-3 highlights considerable opportunities for improvement for HCA. Of the 11 measures with an MPS in CYE 2007, only 1 (9.1 percent) met or exceeded AHCCCS's required MPS. The rate for the Annual Dental Visit measure did not change significantly (55.2 percent in CYE 2006 and 56.0

percent in CYE 2007, p=.107), but it did continue to exceed AHCCCS's MPS of 51 percent. The rate for Well-Child Visits—First 15 Months had a 20.1 percent relative increase. The rate for this measure significantly increased from 49.4 percent in CYE 2006 to 59.3 percent in CYE 2007; however, it was still more than 10 percentage points lower than the AHCCCS MPS (70 percent).

Among the remaining performance measures, 10 exhibited overall declines in performance, including the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services (aggregate and 20–44 Years), Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. In addition, eight of these measures experienced significant decreases ($p \leq .05$). The largest decrease was associated with the EPSDT Participation measure, for which the rate dropped from 70.0 percent in CYE 2006 to 61.7 percent in CYE 2007 ($p < .001$). Further, while the CYE 2007 rate exceeded both the CYE 2006 MPS and Goal, the 11.9 percent decrease pushed HCA's rate below AHCCCS's required MPS (68 percent).

Overall, from a continuous quality improvement perspective, rates for only 3 of the 13 measures (23.1 percent) indicated improvement between the two measurement periods. Of these three measures, only one measure (Well-Child Visits—First 15 Months) showed a statistically significant gain ($p < .001$). In addition, rates for 10 of 13 measures (76.9 percent) exhibited declines, 8 of which were statistically significant ($p \leq .05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was 20.1 percent for Well-Child Visits—First 15 Months while the maximum relative decline was 11.9 percent for EPSDT Participation.

CAPs

HCA was required to complete 10 CAPs for the 11 measures reported in CYE 2007. This number represented 90.9 percent of the measures and included all measures except for Annual Dental Visits. Each of these CAPs correlated with the aspect of care related to access and indicated that HCA members were not receiving services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. Additionally, the large number of CAPs required for HCA suggests compelling opportunities for improvement.

Strengths

Performance for the Annual Dental Visit measure was the only recognized strength for HCA as it was the only rate to exceed the AHCCCS MPS. None of the rates for the other performance measures reached AHCCCS's associated MPS.

Opportunities for Improvement and Recommendations

The 10 required CAPs for HCA represent a clear opportunity for improvement since rates for each of these performance measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. These measures reflect performance related to access to care; therefore, it is recommended that HCA conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of

operation, and transportation limitations, etc.) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with timeliness of care. Based on the findings of its internal review, HCA should use rapid-cycle methodologies to operationalize and monitor carefully selected and targeted improvement activities to positively impact performance rates.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, Adolescent Well-Care Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should consider enhancing current reminder systems or implement new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. Additionally, the Contractor should use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. These interventions make it easier and more convenient for members to receive preventive services and visits. These and other Contractor-selected improvement activities should improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

It is also recommended that HCA evaluate the interventions currently in place to improve the Annual Dental Visit measure. Since this performance measure was a recognized strength for HCA, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult measures. Also, while the Well-Child Visit—First 15 Months measure failed to meet the AHCCCS MPS, its highly significant and substantial increase suggests that current interventions are working to improve the percentage of infants participating in preventive visits. As such, interventions implemented for this measure could be carried over to other performance measures.

Summary

With only one exception (Annual Dental Visits), the entire performance measures area represents a considerable opportunity for improvement. Current results indicate that more than 90 percent of the Contractor's rates were below the expectations set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the Contractor's organization. Additionally, since most changes in the reported rates significantly decreased, the current review does not indicate improvement. Instead, the results suggest the need for significant improvement in the Contractor's performance for these measures.

Maricopa Health Plan

MHP serves eligible, enrolled members in GSA 12 (Maricopa County) and has contracted with AHCCCS since October 1, 1982. At the time of this review, the Contractor had approximately 33,800 members.

Findings

Table 7-4 presents the performance measure rates for MHP. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-4—Performance Measurement Review *for* MHP

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	69.3%	64.3%	NR[B]	NR[B]	N/A[C]	N/A[C]	N/A[C]
12–24 Months	83.3%	70.7%	NR[B]	NR[B]	85%	86%	97%
25 Months–6 Years	69.5%	63.0%	NR[B]	NR[B]	78%	80%	97%
7–11 Years	66.3%	NR[B]	NR[B]	NR[B]	77%	79%	97%
12–19 Years	66.1%	NR[B]	NR[B]	NR[B]	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	74.2%	74.9%	1.0%	p=.415	N/A[C]	N/A[C]	N/A[C]
20–44 Years	70.2%	71.4%	1.7%	p=.368	78%	80%	96%
45–64 Years	79.3%	79.0%	-0.4%	p=.789	83%	84%	96%
Well-Child Visits—First 15 Months	NR[B]	NR[B]	NR[B]	NR[B]	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	56.2%	**48.8%**	-13.1%	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	25.5%	**21.9%**	-14.4%	**p<.001**	37%	38%	50%
Annual Dental Visit	56.0%	57.3%	2.4%	p=.065	51%	57%	57%
EPSDT Participation	60.9%	**59.2%**	-2.7%	**p=.002**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] Due to a change in management during the past two years, MHP members were not included in these measures in CYE 2007. As such, rates and statistical significance were not calculated.

[C] During CYE 2007, the minimum performance standards for the Children's Access to PCPs and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using AHCCCS's CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-4 highlights considerable opportunities for improvement for MHP. Of the eight measures[7-1] with an MPS in CYE 2007, only one (12.5 percent) met or exceeded AHCCCS's required MPS. While the rate for the Annual Dental Visit measure did not change significantly (56.0 percent in CYE 2006 and 57.3 percent in CYE 2007, p=.065), it did continue to exceed AHCCCS's MPS of 51 percent and surpassed both the AHCCCS goal and long-range benchmark. None of the remaining measures showed any sign of improvement.

Among the remaining performance measures, seven exhibited overall declines in performance, including the Children's Access to PCPs (12–24 Months and 25 Months–6 Years), Adults' Access to Preventive/Ambulatory Health Services (aggregate and 20–44 Years), Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. Among these seven measures, the decrease noted in three measures was substantive and statistically significant ($p \leq .05$). Additionally, rates for two of the measures demonstrated a relative decline of greater than 10 percent—i.e., Well-Child Visits—3, 4 5, and 6 Years (-13.2 percent), and Adolescent Well-Care Visits (-14.1 percent). While rates for the Well-Child Visits—3, 4, 5, and 6 Years measure exceeded the CYE 2006 MPS, the statistically significant decrease (from 56.2 percent to 48.8 percent, p=.002) pushed MHP's rate below the minimum required performance level (56 percent).

Overall, from a continuous quality improvement perspective, rates for only 3 of the 10 measures (30.0 percent) indicated improvement between the two measurement periods. Of these three measures, none showed a statistically significant gain ($p \leq .05$). Additionally, rates for 7 of 10 measures (70.0 percent) exhibited declines, 3 of which were statistically significant ($p < .05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was only 2.3 percent for Annual Dental Visits while the maximum relative decline was 13.1 percent for Well-Child Visits—3, 4, 5, and 6 Years.

CAPs

MHP was required to complete seven CAPs for the eight performance measures reported in CYE 2007. This number represented 87.5 percent of the measures and included all measures except for Annual Dental Visits. Each of these CAPs correlated with the access domain of care and indicated that MHP members were not receiving the targeted services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. The large number of CAPs required for MHP suggests considerable opportunities for improvement.

Strengths

Performance for the Annual Dental Visit measure was the only recognized performance measure strength for MHP as it was the only rate to exceed the AHCCCS MPS. None of rates for the other performance measures reached AHCCCS's associated MPS.

[7-1] Due to a change in management at MHP, three of the measures were not calculated during CYE 2007. These measures were Children's Access to PCPs (7–11 Years), Children's Access to PCPs (12–19 Years), and Well-Child Visits—First 15 Months.

Opportunities for Improvement and Recommendations

The seven required CAPs for MHP represent a clear opportunity for improvement since rates for each of these performance measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. Because performance on these measures relates to access, it is recommended that MHP conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, transportation limitations, etc.) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with timeliness of care. Based on the findings of its internal review, MHP should use rapid-cycle methodologies to operationalize and monitor carefully selected and targeted improvement interventions to positively impact its performance on these measures.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, Adolescent Well-Care Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should consider enhancing its current reminder system or explore adding new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. Additionally, the Contractor should use the results of its analysis to remove any identified barriers to accessing care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. Each of these interventions can make it easier and more convenient for members to receive preventive services and visits. These and other Contractor-identified interventions should improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending provider office hours to include early morning, evening, and weekend hours.

It is also recommended that MHP evaluate the interventions currently in place to improve the Annual Dental Visit measure. Since this performance measure was a recognized strength for MHP, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

With only one exception (Annual Dental Visits), the entire performance measures area represents a considerable opportunity for improvement. Current results indicate that approximately 90 percent of the Contractor's rates were below the expectations set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the Contractor's organization. Additionally, since most changes in the reported rates substantively and significantly decreased, the current review does not indicate improvement. Instead, the results suggest widespread opportunities for improvement.

Mercy Care Plan

MCP serves eligible, enrolled members in GSA 2 (La Paz and Yuma counties), GSA 6 (Yavapai County), GSA 10 (Pima County), GSA 12 (Maricopa County), GSA 14 (Graham and Greenlee counties), and limited ZIP Codes in GSA 4 (Coconino County—86336 and 83640) and GSA 8 (Pinal County—85220 and 85242). MCP has been an AHCCCS Contractor since 1983 and had approximately 250,200 acute care members at the time of this annual review.

Findings

Table 7-5 presents the performance measure rates for MCP. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-5—Performance Measurement Review *for* MCP

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	78.8%	**78.1%**	**-0.8%**	**p=.009**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	85.4%	**82.7%**	**-3.2%**	**p<.001**	85%	86%	97%
25 Months–6 Years	77.9%	**78.9%**	**1.2%**	**p=.009**	78%	80%	97%
7–11 Years	77.4%	**75.7%**	**-2.3%**	**p=.002**	77%	79%	97%
12–19 Years	78.1%	**76.8%**	**-1.7%**	**p=.013**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	80.2%	80.4%	0.3%	p=.522	N/A[B]	N/A[B]	N/A[B]
20–44 Years	78.1%	77.9%	-0.2%	p=.710	78%	80%	96%
45–64 Years	85.2%	85.8%	0.7%	p=.277	83%	84%	96%
Well-Child Visits—First 15 Months	56.9%	**60.5%**	**6.3%**	**p=.003**	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	58.5%	**68.0%**	**16.3%**	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	32.3%	**34.6%**	**7.4%**	**p<.001**	37%	38%	50%
Annual Dental Visit	59.7%	**60.7%**	**1.5%**	**p=.002**	51%	57%	57%
EPSDT Participation	72.0%	**73.3%**	**1.9%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-5 highlights mixed performance for MCP. Of the 11 measures with an MPS in CYE 2007, 5 (45.5 percent) met or exceeded AHCCCS's required MPS. Based on the relative percent change, the

Well-Child Visits—3, 4, 5, and 6 Years measure showed the greatest improvement (16.3 percent), significantly increasing from 58.5 percent in CYE 2006 to 68.0 percent in CYE 2007 ($p<.001$). As such, MCP not only met AHCCCS's MPS for this measure, but also exceeded the AHCCCS goal. The rate for the Annual Dental Visit and EPSDT Participation measures also significantly increased in CYE 2007 ($p=.002$ and $p<.001$, respectively), and exceeded both the MPSs and goals for these measures. MCP's Annual Dental Visit rates also exceeded AHCCCS's long-range benchmark of 57 percent. Finally, the rates for Children's Access to PCPs (25 Months–6 Years) and Well-Child Visits—First 15 Months significantly increased in CYE 2007; however, only the Children's Access to PCPs measure met the AHCCCS MPS. The Adults' Access to Preventive/Ambulatory Health Services (45–64 Years) measure remained statistically unchanged ($p=.277$), but continued to exceed both the AHCCCS MPS and goal.

The rates for several other measures (i.e., Adolescent Well-Care Visits, Well-Child Visits—First 15 Months, and Adults' Access to Preventive/Ambulatory Health Services—Aggregate) also exhibited improvement, although the increase reported for the Adults' Access to Preventive/Ambulatory Health Services measure was not statistically significant. The remaining measures (Children's Access to PCPs [except for 25 Months–6 Years] and Adults' Access to Preventive/Ambulatory Health Services [20–44 Years]) exhibited declines in performance, with the differences in the age-group measures for Children's Access to PCPs being statistically significant.

Overall, from a continuous quality improvement perspective, rates for 8 of the 13 measures (61.5 percent) indicated improvement between the two measurement periods. Of these eight measures, six measures exhibited statistically significant gains. Five of 13 measures (38.5 percent) exhibited declines, 4 of which were statistically significant ($p\leq.05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was 16.3 percent for Well-Child Visits—3, 4, 5, and 6 Years while the maximum relative decline was 3.2 percent for Children's Access to PCPs (12–24 Months).

CAPs

MCP was required to complete six CAPs for the 11 performance measures reported in CYE 2007. This number represented 54.5 percent of the measures. MCP was one of two Acute Care Contractors with the lowest number of required CAPs. The measures requiring CAPs included the Children's Access to PCPs (12–24 Months, 7–11 Years, and 12–19 Years), Adults' Access to Preventive/Ambulatory Health Services (20–44 Years), Well-Child Visits—First 15 Months, and Adolescent Well-Care Visit measures. The required CAPs were associated with aspects of care related to the access domain and indicated that MCP members were not receiving services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. The low number of CAPs required for MCP suggests some continued opportunities for improvement.

Strengths

The results from Table 7-5 indicate that the Children's Access to PCPs (25 Months–6 Years), Adults' Preventive/Ambulatory Care (45–64 years), Well-Child Visits (3, 4, 5, 6 Years), Annual Dental Visit, and EPSDT Participation measures are recognized strengths for MCP as each of the CYE 2007 rates (78.9 percent, 85.8 percent, 68.0 percent, 60.7 percent, and 73.3 percent, respectively) exceeded the AHCCCS MPSs and goals. The rate for Annual Dental Visit exceeded the AHCCCS

long-range benchmark. Except for Adults' Access to Preventive/Ambulatory Health Services, rates for these measures exhibited statistically significant increases ($p \leq .05$) between the two most recent measurement periods. None of the rates for other performance measures reached AHCCCS's associated MPS.

Opportunities for Improvement and Recommendations

The six required CAPs for MCP represent a clear opportunity for improvement since the rates for each of the associated measures failed to meet AHCCCS's MPS. These measures included the Children's Access to PCPs (12–24 Months, 7–11 Years, and 12–19 Years), Adults' Access to Preventive/Ambulatory Health Services (20–44 Years), Well-Child Visits—First 15 Months, and Adolescent Well-Care Visit measures. These measures reflect performance related to access; therefore, it is recommended that MCP conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with the timeliness of care. Based on the findings of its internal review, MCP should use rapid-cycle methodologies to operationalize and monitor the effectiveness of carefully selected and targeted additional improvement activities.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, and Adolescent Well-Care Visits can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should enhance its current reminder systems or implement additional physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. In addition, the Contractor should use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. These and other Contractor-selected interventions make it easier and more convenient for members to receive preventive services and interventions and should improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

Given MCP's mixed performance and comparatively low number of CAPs, it is also recommended that MCP evaluate the interventions currently in place to improve the Children's Access to PCPs (25 Months–6 Years), Adults' Preventive/Ambulatory Care (45–64 years), Well-Child Visits (3, 4, 5, 6 Years), Annual Dental Visit, and EPSDT Participation rates. As recognized strengths for MCP, these measures may provide lessons learned from quality improvement activities that may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

Overall, the current results suggest that MCP's performance for the AHCCCS-selected measures have somewhat improved in CYE 2007. Of the 13 evaluated measures, 6 exhibited statistically

significant increases, with rates for 5 measures meeting AHCCCS's MPS and/or goals. In general, the findings demonstrated that slightly more than half of the Contractor's rates were below the expectations set by AHCCCS. The findings suggest some opportunity for continued improvement for MCP.

Pima Health Systems

PHS serves eligible members in GSA 10 (Pima and Santa Cruz counties) and has contracted with AHCCCS since October 1, 1983. At the time of this review, the Contractor had approximately 27,175 Acute Care members.

Findings

Table 7-6 presents the performance measure rates for PHS. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-6—Performance Measurement Review *for* PHS

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	81.7%	**71.4%**	-12.6%	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	82.8%	**64.3%**	-22.4%	**p<.001**	85%	86%	97%
25 Months–6 Years	80.1%	**70.0%**	-12.7%	**p<.001**	78%	80%	97%
7–11 Years	81.9%	**74.0%**	-9.6%	**p<.001**	77%	79%	97%
12–19 Years	83.7%	**74.5%**	-11.0%	**p<.001**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	78.2%	**74.0%**	-5.4%	**p<.001**	N/A[B]	N/A[B]	N/A[B]
20–44 Years	76.9%	**71.0%**	-7.6%	**p<.001**	78%	80%	96%
45–64 Years	80.7%	79.2%	-1.9%	p=.356	83%	84%	96%
Well-Child Visits—First 15 Months	56.9%	56.8%	-0.2%	p=.968	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	57.6%	**44.4%**	-22.9%	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	35.0%	**23.3%**	-33.6%	**p<.001**	37%	38%	50%
Annual Dental Visit	56.5%	57.6%	1.8%	p=.256	51%	57%	57%
EPSDT Participation	76.4%	**54.8%**	-28.2%	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-6 highlights considerable opportunities for improvement for PHS. Of the 11 measures with an MPS in CYE 2007, only 1 (9.1 percent) met or exceeded AHCCCS's required MPS. The rate for the Annual Dental Visit measure did not change significantly (56.5 percent in CYE 2006 and 57.6 percent in CYE 2007, p=.256), but it did continue to exceed AHCCCS's MPS of 51 percent. The 1.8 percent relative change exhibited for this measure moved PHS's Annual Dental Visit rate above

AHCCCS's goal and long-range benchmark (both 57 percent). None of the other evaluated performance measures exhibited any signs of improvement.

Among the 13 calculated performance measures, 12 exhibited overall declines in performance, including the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. Ten of these measures experienced significant decreases ($p<.001$). The largest decrease (33.6 percent) was associated with the Adolescent Well-Care Visit measure, for which the rate dropped from 35.0 percent in CYE 2006 to 23.3 percent in CYE 2007 ($p<.001$). Additionally, seven of the measures showed significant declines of more than 10 percent, of which four had relative changes in excess of 20 percent.

Overall, from a continuous quality improvement perspective, the rate for only 1 of the 13 calculated measures (7.7 percent) indicated improvement between the two measurement periods—i.e., Annual Dental Visits. Across all of the CYE 2007 performance measures, the maximum relative improvement was only 1.8 percent for Annual Dental Visits while the maximum relative decline was 33.6 percent for Adolescent Well-Care Visits.

CAPs

PHS was required to complete 10 CAPs for the 11 performance measures reported in CYE 2007 with an MPS. This number represents 90.9 percent of the measures and included all measures except for Annual Dental Visits. Each of these CAPs reflected performance related to access and indicated that PHS members were not receiving services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. The large number of CAPs required for PHS suggests broad opportunities for improvement.

Strengths

Performance for the Annual Dental Visit measure was the only recognized strength for PHS as it was the only rate to exceed the AHCCCS MPS. The Annual Dental Visit measure also exceeded AHCCCS's goal and long-range benchmark, both of which AHCCCS set at 57 percent. None of the other performance measures' rates reached AHCCCS's associated MPSs.

Opportunities for Improvement and Recommendations

The 10 required CAPs for PHS represent a clear opportunity for improvement since rates for each of the associated measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. These measures reflect performance related to access; therefore, it is recommended that PHS conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with the timeliness of care. Based on the findings of its internal review, PHS should use rapid-cycle methodologies to operationalize and monitor the effectiveness of carefully selected and targeted additional improvement activities.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, Adolescent Well-Care Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should enhance its current reminder system or explore adding new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. The Contractor should also use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. Each of these interventions makes it easier and more convenient for members to receive preventive services and visits. These and other Contractor-selected interventions should work to improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

It is also recommended that PHS evaluate the interventions currently in place to improve the Annual Dental Visit measure. Since this performance measure was a recognized strength for PHS, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

With only one exception (Annual Dental Visits), the entire area of performance for the AHCCCS-selected measures present critical opportunities for improvement. Current results indicate that more than 90 percent of the Contractor's rates were below the expectations set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the Contractor's organization. Since most changes in the reported rates significantly decreased, the current review does not show improvement. Instead, the results suggest overall opportunities for improvement.

Phoenix Health Plan

PHP serves eligible, enrolled members in GSA 8 (Pinal and Gila counties) and GSA 12 (Maricopa County) and has contracted with AHCCCS since 1983. At the time of this review, the Contractor had approximately 91,000 members.

Findings

Table 7-7 presents the performance measure rates for PHP. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-7—Performance Measurement Review *for* PHP

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	77.2%	**74.6%**	**-3.4%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	83.3%	**80.4%**	**-3.5%**	**p=.005**	85%	86%	97%
25 Months–6 Years	77.3%	**75.2%**	**-2.8%**	**p<.001**	78%	80%	97%
7–11 Years	74.9%	**72.6%**	**-3.0%**	**p=.007**	77%	79%	97%
12–19 Years	76.3%	**73.1%**	**-4.3%**	**p<.001**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	77.9%	78.8%	1.2%	p=.124	N/A[B]	N/A[B]	N/A[B]
20–44 Years	76.3%	77.0%	0.9%	p=.327	78%	80%	96%
45–64 Years	81.9%	82.9%	1.2%	p=.329	83%	84%	96%
Well-Child Visits—First 15 Months	54.0%	**59.8%**	**10.7%**	**p=.001**	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	59.0%	**54.5%**	**-7.7%**	**p<.001**	56%	58%	80%
Adolescent Well-Care Visits	31.4%	**29.6%**	**-5.7%**	**p=.010**	37%	38%	50%
Annual Dental Visit	58.5%	**60.4%**	**3.2%**	**p<.001**	51%	57%	57%
EPSDT Participation	70.3%	**66.1%**	**-6.0%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-7 highlights considerable opportunities for improvement for PHP. Of the 11 measures with an MPS in CYE 2007, only 1 (9.1 percent) met or exceeded AHCCCS's required MPS. The rate for the Annual Dental Visit measure significantly increased from 58.5 percent in CYE 2006 to 60.4 percent in CYE 2007 (p<.001) and continued to exceed AHCCCS's MPS, goal, and long-range

benchmark (51 percent, 57 percent, and 57 percent, respectively). None of the other evaluated performance measures exhibited any signs of improvement.

Additionally, the rates for several other measures (i.e., Adults' Access to Preventive/Ambulatory Health Services and Well-Child Visits—First 15 Months) increased in CYE 2007. Of note is the 10.7 percent relative increase in the rate for the Well-Child Visits—First 15 Months measure. This increase was statistically significant ($p<.001$) and suggested overall improvement for the measure despite failing to meet the MPS. Further, while the rate for Adults' Access to Preventive/Ambulatory Health Services (20–44 Years and 45–64 Years) remained statistically unchanged, the CYE 2007 rate was just below the AHCCCS MPS. All of the remaining measures exhibited overall declines in performance. These measures were Children's Access to PCPs, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation. Of these eight measures, all of the noted decreases were statistically significant ($p\leq.05$).

Overall, from a continuous quality improvement perspective, the rates for only 5 of the 13 measures (38.5 percent) indicated improvement between the two measurement periods—i.e., Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, and Annual Dental Visits. Eight of 13 measures (61.5 percent) exhibited declines, all of which were statistically significant ($p\leq.05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was only 10.7 percent for Well-Child Visits—First 15 Months while the maximum relative decline was 7.7 percent for Well-Child Visits—3, 4, 5, and 6 Years.

CAPs

PHP was required to complete 10 CAPs for the 11 performance measures reported in CYE 2007. This number represented 90.9 percent of the measures and included all measures except for Annual Dental Visits. Each of these CAPs reflected performance related to access and indicated that PHP members were not receiving services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. The large number of CAPs required for PHP suggests broad opportunities for improvement.

Strengths

Performance for the Annual Dental Visit measure was the only recognized strength for PHP as it was the only rate to exceed the AHCCCS MPS. The Annual Dental Visit measure rate also exceeded AHCCCS's goal and long-range benchmark, both of which AHCCCS set at 57 percent. None of the other performance measures' rates reached AHCCCS's associated MPSs.

Opportunities for Improvement and Recommendations

The 10 required CAPs for PHP represented a clear opportunity for improvement since rates for each of these performance measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, Adolescent Well-Care Visits, and EPSDT Participation measures. To enhance access to these services, it is recommended that PHP conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and

the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with the timeliness of care. Based on the findings of its internal review, PHP should use rapid-cycle methodologies to operationalize and monitor the effectiveness of carefully selected and targeted additional improvement activities.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, Adolescent Well-Care Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should enhance its current reminder systems and/or implement additional physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. The Contractor should also use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. These interventions make it easier and more convenient for members to receive preventive services and visits. These and other Contractor-selected strategies should improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

It is also recommended that PHP evaluate the interventions currently in place to improve the Annual Dental Visit measure. Since this performance measure was a recognized strength for PHP, lessons learned from quality improvement activities may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

With only one exception (Annual Dental Visits), the entire performance measure area represents a compelling opportunity for improvement. Current results indicate that more than 90 percent of the Contractor's rates were below the expectations set by AHCCCS, suggesting the need to implement continuous improvement methodologies throughout the Contractor's organization. Since most of the changes in reported rates significantly decreased, the current review does not show improvement. Instead, the results suggest high-priority opportunities for improvement.

University Family Care

UFC serves eligible, enrolled members in GSA 10 (Pima County) and has contracted with AHCCCS since October 1, 1997. At the time of this review, the Contractor had approximately 8,200 members.

Findings

Table 7-8 presents the performance measure rates for UFC. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-8—Performance Measurement Review *for* UFC

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	81.2%	**78.6%**	**-3.2%**	**p=.004**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	87.0%	86.1%	-1.0%	p=.797	85%	86%	97%
25 Months–6 Years	78.0%	75.3%	-3.5%	p=.097	78%	80%	97%
7–11 Years	80.5%	**75.5%**	**-6.2%**	**p=.008**	77%	79%	97%
12–19 Years	83.7%	82.6%	-1.4%	p=.406	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)	80.1%	79.6%	-0.6%	p=.688	N/A[B]	N/A[B]	N/A[B]
20–44 yrs	78.5%	77.0%	-1.9%	p=.353	78%	80%	96%
45–64 yrs	82.7%	83.2%	0.6%	p=.772	83%	84%	96%
Well-Child Visits—First 15 Months	60.2%	61.3%	1.8%	p=.852	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	55.8%	53.4%	-4.4%	p=.310	56%	58%	80%
Adolescent Well-Care Visits	38.7%	41.2%	6.6%	p=.131	37%	38%	50%
Annual Dental Visit	56.9%	58.1%	2.1%	p=.305	51%	57%	57%
EPSDT Participation	74.2%	**67.4%**	**-9.1%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-8 highlights mixed performance for UFC. Of the 11 measures with an MPS in CYE 2007, 5 (45.5 percent) met or exceeded AHCCCS's required MPS. These measures included the Children's Access to PCPs (12–24 Months and 12–19 Years), Adults' Access to Preventive/Ambulatory Health Services (45–64 Years), Adolescent Well-Care Visits, and Annual Dental Visit measures. None of

these measures experienced a statistically significant change in rates during CYE 2007. Rates for four of these measures met or exceeded AHCCCS' goal, and one measure (Annual Dental Visits) exceeded the AHCCCS long-range benchmark.

Except for the Well-Child Visits—First 15 Months measure, the rates for the remaining performance measures exhibited declines in performance, with the differences for the Children's Access to PCPs (Aggregate), Children's Access to PCPs (7–11 Years), and EPSDT Participation measures being statistically significant. Importantly, the reported decreases for all of these measures, except for the Well-Child Visits—3, 4, 5, and 6 Years, caused UFC's performance to drop below AHCCCS's MPS.

Overall, from a continuous quality improvement perspective, only 4 of the 13 total measures (30.8 percent) indicated improvement between the two measurement periods. Of these four measures, none exhibited statistically significant gains ($p \leq .05$). In addition, more than two-thirds of the measures (69.2 percent) exhibited declines, three of which were statistically significant ($p \leq .05$). Across all of the CYE 2007 performance measures, the maximum relative improvement was 6.6 percent for Adolescent Well-Care Visits while the maximum relative decline was 9.1 percent for EPSDT Participation.

CAPs

UFC was required to complete six CAPs for the 11 performance measures reported in CYE 2007. This number represents 54.5 percent of the measures and the lowest number of CAPs required for the Contractors. (Only one other Contractor had this number of required CAPs.) The measures requiring CAPs included the Children's Access to PCPs (25 Months–6 Years and 7–11 Years), Adults' Access to Preventive/Ambulatory Health Services (20–44 Years), Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, and EPSDT Participation measures. Each of these CAPs reflected performance related to access to care and indicated that UFC's members were not receiving services at rates that met AHCCCS's MPSs, goals, or long-range benchmarks. Additionally, the number of CAPs required for UFC suggests clear opportunities for improvement.

Strengths

The results from Table 7-8 indicate that performance for the Children's Access to PCPs (12–24 Months and 12–19 Years), Adolescent Well-Care Visits, and Annual Dental Visit measures are recognized strengths for UFC as each of the CYE 2007 rates (86.1 percent, 82.6 percent, 41.2 percent, and 58.1 percent, respectively) exceeded the AHCCCS MPSs and goals. In addition, the rate for Annual Dental Visit exceeded the AHCCCS long-range benchmark. While none of these measures exhibited a statistically significant increase ($p \leq .05$) between the two most recent measurement periods, UFC's performance suggested consistently high performance on these measures. None of the other performance measures' rates reached AHCCCS's associated MPS.

Opportunities for Improvement and Recommendations

The six required CAPs for UFC represented a clear opportunity for improvement since rates for each of these performance measures failed to meet AHCCCS's MPSs. These measures included the Children's Access to PCPs (25 Months–6 Years and 7–11 Years), Adults' Access to

Preventive/Ambulatory Health Services (20–44 Years), Well-Child Visits—First 15 Months, Well-Child Visits—3, 4, 5, and 6 Years, and EPSDT Participation measures. As these measures are associated with issues of access, it is recommended that UFC conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with the timeliness of care. Based on the findings of its internal review, UFC should use rapid-cycle methodologies to operationalize and monitor the effectiveness of additional quality improvement interventions.

In general, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should enhance current reminder systems or explore adding new physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. The Contractor should also use the results of its analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending provider office hours, contracting with additional providers, and/or providing enhanced transportation options for members. These interventions make it easier and more convenient for members to receive preventive services and visits. These and other Contractor-selected interventions should improve the overall rate of preventive visits received by children, adolescents, and adults. The Contractor should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending office hours to include early morning, evening, and weekend hours.

Given UFC's mixed performance and comparatively low number of CAPs, it is also recommended that UFC evaluate the interventions currently in place to improve the Children's Access to PCPs (12–24 Months and 12–19 Years), Adolescent Well-Care Visits, and Annual Dental Visit rates. Since these measures were recognized strengths for UFC, lessons learned from quality improvement activities associated with these measures may be useful in improving the rates for other child, adolescent, and adult measures.

Summary

Overall, the current results suggest that for the most part, UFC's performance for the AHCCCS-selected measures did not improve in CYE 2007. Of the 13 evaluated measures, 6 remained statistically unchanged, with 5 measures continuing to meet or exceed AHCCCS's MPSs and/or goals. However, rates for three of the measures decreased significantly, leading to required CAPs. In general, the findings showed that slightly more than half of the Contractor's rates were below the expectations set by AHCCCS. The findings suggest broad opportunity for improvement for UFC.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program (DES/CMDP)

DES/CMDP serves eligible, enrolled members in all GSAs and has contracted with AHCCCS since 2003. At the time of this review, the Contractor had approximately 9,400 members.

Findings

Table 7-9 presents the performance measure rates for DES/CMDP. The table displays the following information: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and AHCCCS's CYE 2007 MPS, goal, and long-range benchmark.

Table 7-9—Performance Measurement Review *for* DES/CMDP

Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs	88.0%	**85.1%**	**-3.3%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	92.4%	89.2%	-3.5%	p=.076	85%	86%	97%
25 Months–6 Years	84.2%	**80.9%**	**-4.0%**	**p=.009**	78%	80%	97%
7–11 Years	86.7%	83.0%	-4.3%	p=.121	77%	79%	97%
12–19 Years	93.1%	91.5%	-1.7%	p=.188	79%	81%	97%
Well-Child Visits—3, 4, 5, 6 Years	68.6%	65.9%	-4.0%	p=.159	56%	58%	80%
Adolescent Well-Care Visits	64.6%	65.1%	0.9%	p=.718	37%	38%	50%
Annual Dental Visit	78.4%	79.2%	1.1%	p=.369	51%	57%	57%
EPSDT Participation	100%	100%	0.0%	NR[C]	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2007.

[C] A value of "NR" indicates that statistical testing was not done since the rate remained at 100 percent in CYE 2007.

Using the AHCCCS CYE 2007 MPSs, goals, and long-range benchmarks as frames of reference, Table 7-9 highlights exceptional performance for DES/CMDP. Of the eight measures with an MPS in CYE 2007[7-2], all of the rates met or exceeded both AHCCCS's MPSs and goals. In addition, the rates for the Adolescent Well-Care Visits, Annual Dental Visits, and EPSDT Participation measures exceeded the associated AHCCCS long-range benchmarks. Overall, from a continuous quality improvement perspective, only the Adolescent Well-Care Visits and Annual Dental Visit measures indicated improvement between the two measurement periods while the EPSDT Participation measure maintained a rate of 100 percent. Neither of the two increasing rates, however, showed a

[7-2] The Adults' Access to Preventive/Ambulatory Health Services and Well-Child Visits—First 15 Months measures were not required for DES/CMDP in CYE 2007.

statistically significant gain (p≤.05). Of the remaining measures, rates for all six exhibited declines in performance, with only the Children's Access to PCPs (aggregate and 25 Months–6 Years) measures showing differences that were statistically significant (p≤.05). The maximum relative improvement was 1.1 percent for Annual Dental Visit while the maximum relative decline was 4.3 percent for Children's Access to PCPs—7–11 years.

CAPs

DES/CMDP did not have any CAPs required for its performance for the AHCCCS-selected measures during the current review period.

Strengths

With no required CAPs during CYE 2007, the entire area of performance measures is recognized as a commendable strength for DES/CMDP.

Opportunities for Improvement and Recommendations

The results from the performance measure review do not suggest any opportunities for improvement at this time. Consistent with ongoing improvement and maintenance of current performance, HSAG recommends that DES/CMDP regularly monitor and review its rates to ensure continued success and to prevent continued declines in some measures, such as Children's Access to PCPs.

Summary

DES/CMDP has shown very strong results for the performance measure review. All of its performance measure rates exceeded both AHCCCS's MPSs and goals, with rates for three measures exceeding the respective long-range benchmarks. As the only Contractor with no required CAPs in CYE 2007, DES/CMDP demonstrated exceptional performance for the AHCCCS-selected measures.

Comparative Results for Acute Care and DES/CMDP Contractors

AHCCCS calculated and reported the Acute Care and DES/CMDP Contractor rates for the same set of performance measures in CYE 2007 as in CYE 2006. In general, the methodologies for generating the rates remained constant over the two-year period, ensuring the comparability of the results across years. Only the programming for the Children's Access to PCPs measure was modified by AHCCCS in order to conform to current HEDIS requirements. However, due to changes in AHCCCS's required MPSs and goals, the two-year comparisons are somewhat limited.

Findings

Table 7-10 presents the mean rates across the nine Acute Care and DES/CMDP Contractors. The table shows the following: the previous performance, the current performance, the relative percent change, the statistical significance of the change, and CYE 2007 AHCCCS MPSs, goals, and long-range benchmarks.

Table 7-10—Performance Measurement Review *for* Acute Care and DES/CMDP Contractors							
Performance Measure	Performance for Oct. 1, 2004, to Sept. 30, 2005	Performance for Oct. 1, 2005, to Sept. 30, 2006	Relative Percent Change	Significance Level[A]	CYE 2007 Minimum Performance Standard	AHCCCS Goal	AHCCCS Long-Range Benchmark
Children's Access to PCPs[E] (Total)	78.3%	**75.8%**	**-3.3%**	**p<.001**	N/A[B]	N/A[B]	N/A[B]
12–24 Months	84.9%	**81.0%**	**-4.6%**	**p<.001**	85%	86%	97%
25 Months–6 Years	77.1%	**75.4%**	**-2.2%**	**p<.001**	78%	80%	97%
7–11 Years[C]	76.8%	**74.1%**	**-3.5%**	**p<.001**	77%	79%	97%
12–19 Years[C]	78.9%	**75.9%**	**-3.7%**	**p<.001**	79%	81%	97%
Adults' Access to Preventive/Ambulatory Health Services (Total)[D]	79.2%	79.5%	0.4%	p=.081	N/A[B]	N/A[B]	N/A[B]
20–44 Years[D]	77.3%	77.3%	0.0%	p=.885	78%	80%	96%
45–64 Years[D]	83.4%	**84.1%**	**0.8%**	**p=.020**	83%	84%	96%
Well-Child Visits—First 15 Months[D]	54.0%	**58.0%**	**7.3%**	**p<.001**	70%	72%	90%
Well-Child Visits—3, 4, 5, 6 Years	58.3%	58.5%	0.4%	p=.514	56%	58%	80%
Adolescent Well-Care Visits	33.1%	32.8%	-0.9%	p=.201	37%	38%	50%
Annual Dental Visit	58.2%	**59.6%**	**2.4%**	**p<.001**	51%	57%	57%
EPSDT Participation	69.7%	**65.0%**	**-6.6%**	**p<.001**	68%	69%	80%

[A] Significance levels (*p* values) noted in the table were calculated by AHCCCS and demonstrated the statistical significance between performance during the previous measurement period and the current measurement period. Statistical significance is traditionally reached when the *p* value is ≤ .05. Rates in bold indicate statistical significance.

[B] During CYE 2007, the minimum performance standards for the Children's Access to PCP's and Adults' Preventative/Ambulatory Care measures were established for individual age groups instead of at the aggregate level, as they were in CYE 2006.

[C] Due to a change in management, MHP members were not included in the current measurement.

[D] DES/CMDP was not included in the current measurement.

[E] AHCCCS updated its programming for the Children's Access to PCPs measure in order to better conform to current HEDIS methodology. These updates may have resulted in a decline in the rates for these measures.

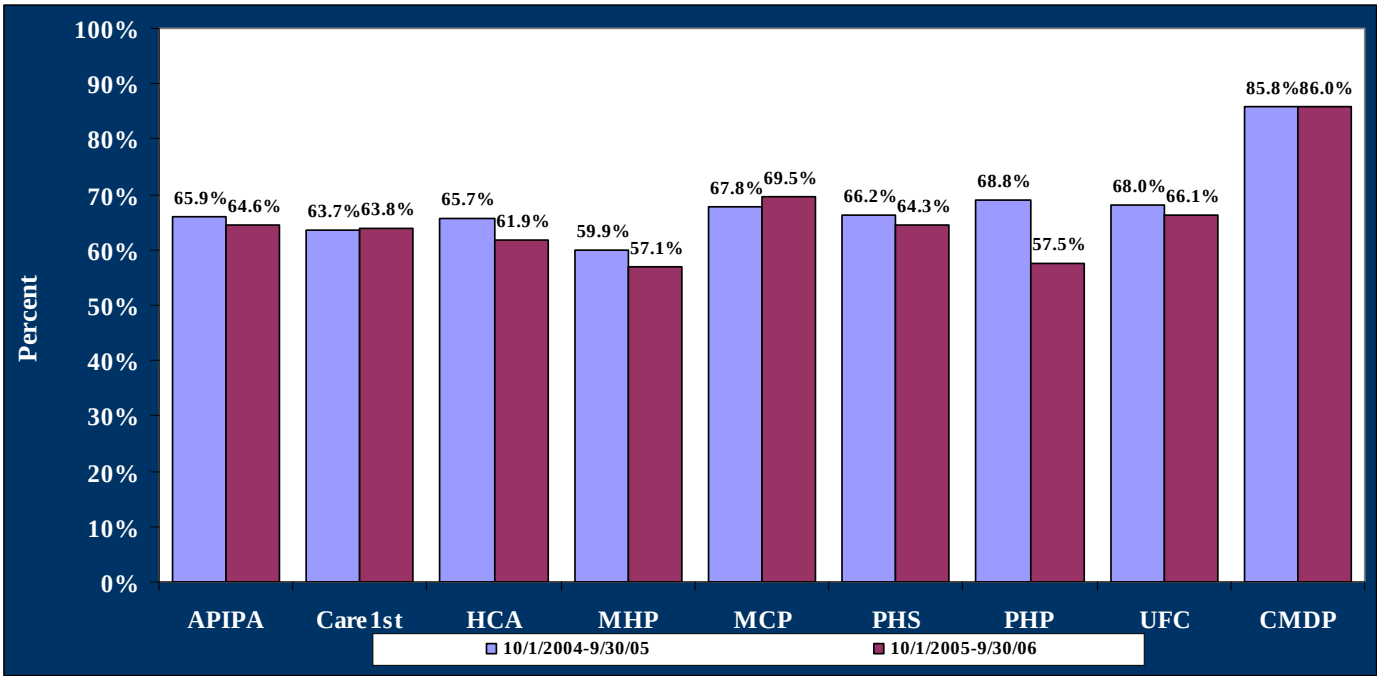
Using the CYE 2007 MPS, goals, and long-range benchmarks as frames of reference, the Acute Care and DES/CMDP Contractors showed considerable opportunity for improvement as only 27.3 percent of the reported rates for the measures with an MPS in CYE 2007 met or exceeded AHCCCS's MPS. Additionally, Table 7-10 shows small but statistically significant declines between the two most recent review periods, especially for the Children's Access to PCPs measures. In total, rates for 7 of the 13 measures decreased, with 6 of the measures exhibiting statistically significant (p< .001) declines in performance (Children's Access to PCPs and EPSDT Participation). However, declines in the Children's Access to PCPs measure may have resulted from programming changes implemented during the current measurement period. Of the remaining six reported measures, three showed statistically significant (p=.020 or less) increases in performance (Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years, Well-Child Visits—First 15 Months, and Annual Dental Visit). Three of the performance measure rates were above the

respective AHCCCS goal while the rate for one measure (Annual Dental Visit) was above the AHCCCS long-range benchmark. Overall, the average rate across all performance measures suggests a small decline from 69.9 percent (CYE 2006) to 69.0 percent (CYE 2007), although statistical testing was not done for the overall average.

From a continuous quality improvement perspective, Table 7-10 shows generally flat performance statewide. Three of the five measures showed gains that reached statistical significance ($p \leq .05$)—i.e., Adults' Access to Preventive/Ambulatory Health Services (45–64 Years), Well-Child Visits—First 15 Months, and Annual Dental Visit. The Adults' Access to Preventive/Ambulatory Health Services (20–44 Years) measure showed no change at all between measurement cycles. Finally, of the seven performance measure rates that declined, six of the decreases were statistically significant ($p \leq .05$), including all age groups for Children's Access to PCPs. The maximum relative improvement was 7.4 percent for Well-Child Visits—First 15 Months while the maximum relative decline was 6.7 percent for EPSDT Participation.

Figure 7-1 presents the average rates for the performance measures for Acute Care and DES/CMDP Contractors. The figure presents the CYE 2006 and CYE 2007 performance measure rates averaged across 11 of the 13 performance measures shown in Table 7-10. The Children's Access to PCPs (Total) and Adult's Access to Preventive/Ambulatory Care (Total) measures were excluded from the weighted average calculation since these rates include the individual age-specific rates.

Figure 7-1—Current and Previous Average Performance Measure Rates *for* Acute Care and DES/CMDP Contractors[7-3]



Note: The overall weighted average for the DES/CMDP Contractor includes fewer measures than for the Acute Care Contractors. The Adult's Access to Preventive/Ambulatory Care measure was not included in the overall weighted average for the DES/CMDP Contractor.

In general, Figure 7-1 shows that the overall rate declined for six of the nine Contractors over the two most recent measurement periods. These declines ranged from 1.3 percentage points (PHP) to 11.4 percentage points (PHS). The largest increase among the three Contractors showing an increase in rates was only 1.7 percentage points, indicating minimal overall change. Figure 7-1 also highlights the consistently high performance for DES/CMDP in both measurement periods. The average performance measure rate for the next-highest-performing Contractor was more than 10 percentage points lower. MHP returned the lowest average score during both measurement periods.

Figure 7-2 presents the results for the 11 performance measures with a MPS for both measurement periods along with the AHCCCS MPS. For each of the performance measures, the figure indicates the AHCCCS MPS, the average rate for the previous measurement period, and the average rate for the current measurement period across all Acute Care and DES/CMDP Contractors.

[7-3] The Contractors' names are abbreviated as follows: APIPA= Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health Services, PHP=Phoenix Health Plan, UFC=University Family Care, and Arizona Department of Economic Security/Comprehensive Medical and Dental Program=DES/CMDP.

Figure 7-2—MPS, Previous, and Current Performance Measure Rates *for* Acute Care and DES/CMDP Contractors[7-4]

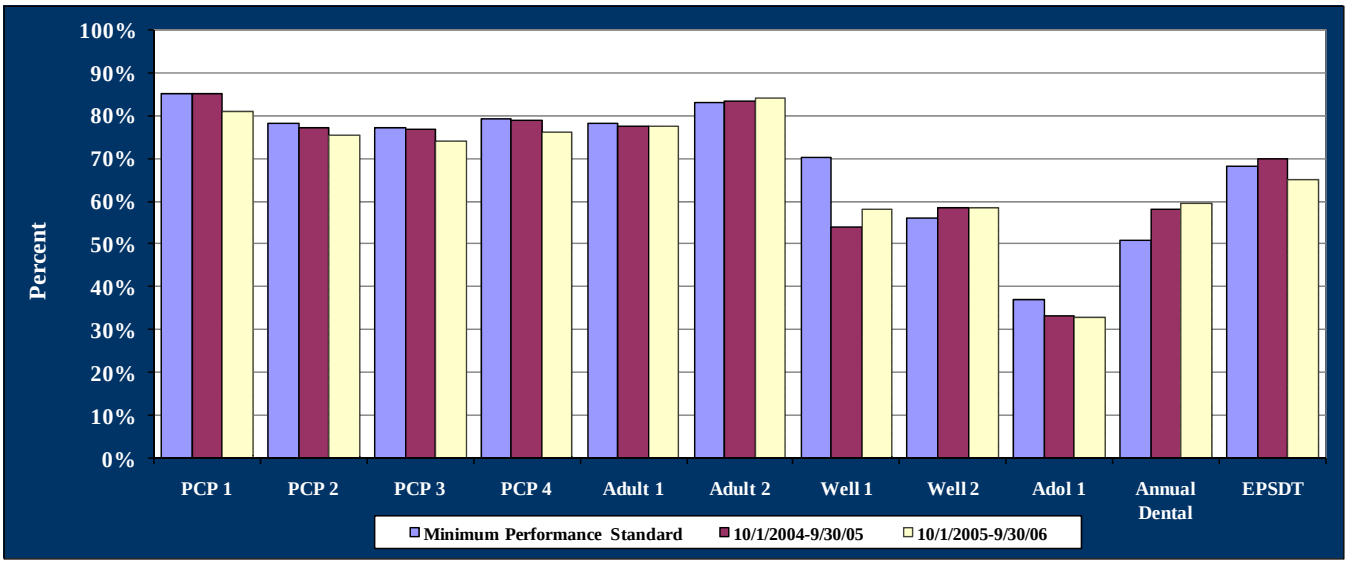


Figure 7-2 illustrates that the rates for the Children's Access to PCPs (12–24 Months) and Adults' Access to Preventive/Ambulatory Health Services (45–64 Years) measure rates are clearly higher than for any of the other measures for both the previous and current measurement periods. Conversely, Adolescent Well-Care Visits has shown substantively and consistently lower results than the other measures. However, the most important finding from Figure 7-2 is that most of the average performance measure rates across all Contractors were either stagnant or slightly declining. Five of the 11 measures in the figure show a decline, 3 measures show essentially unchanged performance, and 3 of the measures show an improvement.

Table 7-11 presents the number of required CAPs for Acute Care and DES/CMDP Contractors during CYE 2006 and CYE 2007 for comparable performance measures during both reporting periods.[7-5] The table shows each of the performance measures, the previous number of CAPs required, the CYE 2006 MPS, the current number of CAPs required, and the CYE 2007 MPS. The MPS increased for four of the five measures presented in the table. Although the changes to the MPS could impact the number of CAPs required, Contractors are expected to implement quality improvement efforts that are at least commensurate with the increases in MPS rates.

[7-4] The performance measure names have been abbreviated as follows: PCP1=Children's Access to PCPs (12–24 Months); PCP2=Children's Access to PCPs (25 Months–6 Years); PCP3=Children's Access to PCPs (7–11 Years); PCP4=Children's Access to PCPs (12–19 Years); Adult1=Adults' Access to Preventive/Ambulatory Health Services (20–44 Years); Adult2=Adults' Access to Preventive/Ambulatory Health Services (45–64 Years); Well1=Well-Child Visits—First 15 Months; Well2=Well-Child Visits—3, 4, 5, and 6 Years; Adol1=Adolescent Well-Care Visits; Annual Dental=Annual Dental Visit; EPSDT=Annual EPSDT Participation.

[7-5] In CYE 2006, AHCCCS MPSs, goals, and long-range benchmarks for the Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services measures were established at the aggregate level. However, in CYE 2007, AHCCCS redefined performance standards for these measures at the age-group level. As a result, comparisons of the number of CAPs for these measures are not possible.

Table 7-11—Performance Measures—Corrective Action Plans Required *for* Acute Care and DES/CMDP Contractors				
	CYE 2006		CYE 2007	
Performance Measure	Number of CAPs (10/1/2004–9/30/2005)	Minimum Performance Standard	Number of CAPs (10/1/2005–9/30/2006)	Minimum Performance Standard
Well-Child Visits—First 15 Months[A]	7	70%	7	70%
Well-Child Visits—3, 4, 5, 6 Years	1	55%	6	56%
Adolescent Well-Care Visits	3	32%	7	37%
Annual Dental Visit	0	49%	0	51%
EPSDT Participation	0	58%	6	68%
Total	**11**		**26**	

[A] MHP and DES/CMDP were not included in this measure.

Table 7-11 highlights three primary findings from this review. First, the current review cycle saw a marked increase in the number of required CAPs for the five measures with a continuing MPS from 11 CAPs in CYE 2006 to 26 CAPs in CYE 2007. This increase of 15 CAPs represents a 136.4 percent increase in the opportunities for improvement found overall across Acute Care and DES/CMDP Contractors. Second, the number of required CAPs increased for the Well-Child Visits—3, 4, 5, 6 Years, Adolescent Well-Care visits, and EPSDT Participation measures, but remained constant for Well-Child Visits—First 15 Months. Third, the Annual Dental Visit measure was the only measure to remain without a CAP. Notably, DES/CMDP had no required CAPs in CYE 2007. The next-lowest number of CAPs for an Acute Care Contractor was six CAPs required for two Acute Care Contractors.

Strengths

The Annual Dental Visit measure is a clear strength across all nine Acute Care and DES/CMDP Contractors; no CAPs were required for this measure during the past two measurement periods. All of the remaining performance measures required at least five CAPs in CYE 2007. Additionally, DES/CMDP exhibited the strongest performance across all Contractors.

Opportunities for Improvement and Recommendations

Based on the results of this review, current quality improvement efforts are not yielding the desired improvement in Acute Care Contractor performance. Across comparable performance measures with an MPS, the number of required CAPs has increased by 136.4 percent, from 11 CAPs in CYE 2006 to 26 CAPs in CYE 2007. However, some of the increase in CAPs may be related to the increase in the MPS implemented by AHCCCS between the review periods. In total, AHCCCS required the Acute Care Contractors to complete 65 CAPs in CYE 2007. DES/CMDP's strong performance resulted in no required CAPs.

Since continuing current quality improvement activities is unlikely to result in positive change in the performance measure rates, the Acute Care Contractors should conduct a causal/barrier analysis to evaluate the relationship between structural access parameters (e.g., numbers and distributions of providers, hours of operation, and transportation limitations) and the performance measures requiring a CAP. It is also important to note that these measures can reflect issues associated with timeliness of care. Based on the findings of this analysis, the Acute Care Contractors should use rapid-cycle methodologies to operationalize and monitor future interventions.

As noted previously for each of the Acute Care Contractors, improving the rates for access-based measures such as Children's Access to PCPs, Well-Child Visits, and EPSDT Participation can be more difficult than for other measures since they require action on the part of the child's or adolescent's caregiver. However, improvement in these measures can often be accomplished by implementing a combination of interventions. For example, the Contractor should consider enhancing current reminder systems or implement additional physician and/or member reminder systems. These notification systems function to ensure members and providers are prompted to schedule and keep appointments for appropriate preventive services at recommended intervals. Contractors should use the results of their analysis to remove any identified barriers to care. Improved access to physician offices can frequently be achieved by extending office hours, contracting with additional providers, and/or providing enhanced transportation options for members. Each of these interventions makes it easier and more convenient for members to receive preventive services and visits. Contractors should also consider analyzing the availability of physicians offering services to working adults. Interventions could include extending provider office hours to include early morning, evening, and weekend hours.

Considering the extent of improvement in performance needed across the Acute Care Contractors, in addition to addressing the barriers to successful performance and actions to improve it at the individual Contractor organizational level, Contractors should consider convening a collaborative Contractor work group. This would allow the Contractors to share best practices that have been successful in improving performance for these or other measures in the past, and capitalize on the larger pool of participants to identify the overarching factors contributing to the failure to substantively improve performance and to identify strategic associated improvement strategies.

Summary

Overall, the Acute Care performance measure rates illustrate somewhat declining rates when compared to the rates in CYE 2006. The DES/CMDP Contractor exhibited exceptional performance, with no CAPs required. These results suggest that aggressive modifications to existing quality improvement activities are required to bring the Acute Care Contractors' performance into alignment with AHCCCS's expectations and MPS. The one highlight of the performance review across Contractors was the finding that rates for the Annual Dental Visit measure remained above the AHCCCS MPS for all Acute Care and DES/CMDP Contractors.

In accordance with 42 CFR 438.240(d), AHCCCS contractually requires Contractors to have a QAPI program that: (1) includes an ongoing program of PIPs designed to achieve favorable effects on health outcomes and enrollee satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve improvement in quality
- Evaluating the effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The CFR citation above also requires each PIP to be completed in a reasonable time to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year.

One of the three external review-related activities mandated by the BBA and described at 42 CFR 438.358(b)(1) is the annual validation of MCO and PIHP PIPS that were required by the state and under way during the preceding 12 months. The requirement at 438.358(a) allows a state, its agent that is not an MCO or PIHP, or an EQRO to conduct the mandatory and optional EQR-related activities. AHCCCS elected to conduct the functions associated with the BBA mandatory activity of validating its Contractors' PIPs. In accordance with, and satisfying, the requirements of 42 CFR 438.364(a)(1), AHCCCS contracted with HSAG as an EQRO to use the information AHCCCS obtained from its PIP data collection, calculation, and validation activities to prepare this 2006–2007 annual report.

Conducting the Review

AHCCCS requires Contractors to participate in AHCCCS-selected PIPs. The mandated PIP topics:

- Are selected through the analysis of internal and external data and trends and through Contractor input.
- Take into account comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members.

AHCCCS performs data collection and analysis for baseline and successive measurements, and reports performance results of mandated PIPs for each Contractor and across Contractors.

In CYE 2007, AHCCCS completed its analysis of the first remeasurement data for the Acute Care Contractors and DES/CMDP for a PIP to improve provider reporting to the Arizona State Immunization Information System (ASIIS), the State's vaccine registry for children. In addition, for those Contractors that had not yet successfully completed the Children's Oral Health/Dental Visits PIP, AHCCCS completed an analysis of the Contractors' remeasurement data. Some of the

Contractors were also working to complete a PIP to improve immunization completion rates by 24 months of age.

Objectives for Conducting the Review

In its objectives for evaluating Contractor PIPs, AHCCCS:

- Ensured that each Contractor had an ongoing performance improvement program of projects that focused on clinical and/or nonclinical areas for the services it furnished to members.
- Ensured that each Contractor measured performance using objective and quantifiable quality indicators.
- Ensured that each Contractor implemented systemwide interventions to achieve improvement in quality.
- Evaluated the effectiveness of each Contractor's interventions.
- Ensured that each Contractor planned and initiated activities to increase or sustain its improvement.
- Ensured that each Contractor reported to the State data/information it collected for each project in a reasonable period to allow timely information on the status of PIPs.
- Calculated and validated the PIP results from the Contractor data/information.
- Reviewed the impact and effectiveness of each Contractor's performance improvement program.
- Required each Contractor to have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

HSAG designed a summary tool to organize and represent the information and data AHCCCS provided for the nine Acute Care and DES/CMDP Contractors' performance with respect to the AHCCCS-selected PIPs. The summary tool focused on HSAG's objectives for aggregating and analyzing the data, which were to:

- Determine Contractor performance on the AHCCCS-selected PIPs.
- Provide data from analyzing the PIP results that would allow HSAG to draw conclusions about the quality and timeliness of, and access to, care and services furnished by individual Contractors and statewide across the Contractors.
- Assess the Contractor improvement interventions to provide an overall evaluation of performance for each Contractor and statewide across Contractors.

Methodology for Conducting the Review

AHCCCS develops a methodology to measure performance in a standardized way across Contractors for each mandated PIP and follows quality control processes to ensure the collection of valid and reliable data. The study indicators AHCCCS selects for each PIP are based on current clinical knowledge or health services research. The methodology states the study question, the population(s) included, any sampling methods, and methods to collect the data. AHCCCS collects the data from the encounter subsystem of its PMMIS system. To ensure the reliability of the data,

AHCCCS conducts data validation studies to evaluate the completeness, accuracy, and timeliness of the data. AHCCCS may also request that Contractors collect additional data (e.g., the diabetes PIP). In these cases, AHCCCS requires the Contractors to submit documentation to verify that indicator criteria were met.

Following data collection and encounter validation, AHCCCS reports Contractor results and an analysis and discussion of possible interventions. Contractors conduct additional analysis of their data and performance improvement interventions. Remeasurement of performance is conducted in the third year of a PIP. AHCCCS requires Contractors to evaluate the effectiveness of their interventions and report to AHCCCS the results of their evaluation and any new or revised interventions. Contractors whose performance does not demonstrate improvement from baseline to remeasurement are required to report to AHCCCS their proposed actions to revise, replace, and/or initiate new interventions.

To determine if improved Contractor performance is sustained, AHCCCS conducts a second remeasurement. If Contractors do not sustain their performance, they must report to AHCCCS their planned changes to interventions.

If results of the second remeasurement demonstrate that a Contractor's performance was both improved and the improvement was sustained, AHCCCS considers the PIP closed for that Contractor. If the Contractor's performance was not improved and the improvement was not sustained, the PIP remains open and continues for another remeasurement cycle. When a PIP is considered closed for a Contractor, the Contractor's final report and any follow-up or ongoing activities are due 180 days after the end of the project (typically the end of the contract year). AHCCCS prepared a standardized format for documenting PIP activities (Performance Improvement Project Reporting Format). AHCCCS encourages Contractors to use the PIP Reporting Format to document their analyses of baseline and remeasurement results, implementation of interventions, and assessment of improvement.

AHCCCS conducted its review and assessment of Contractor performance using the applicable criteria found in *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). The protocol includes 10 distinct steps:

- Review the selected study topic(s)
- Review the study question(s)
- Review the selected study indicator(s)
- Review the identified study population(s)
- Review the sampling methods (if sampling was used)
- Review the Contractor's data collection procedure
- Assess the Contractor's improvement strategies
- Review the data analysis and the interpretation of the study's results
- Assess the likelihood that reported improvement is real improvement
- Assess whether the Contractor has sustained its documented improvement.

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step.

As noted above, not all steps were applicable to AHCCCS's evaluation of the Contractors' performance because AHCCCS:

- Selected the study topics, questions, indicators, and populations.
- Defined sampling methods, if applicable.
- Collected all or part of the data.
- Calculated Contractor performance rates.

Throughout the process, AHCCCS maintained confidentiality in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

AHCCCS provided the overall evaluation reports and plan-specific results to HSAG for its review and analysis for this 2006–2007 annual report.

Based on its analysis of the data, HSAG drew conclusions about Contractor-specific and statewide aggregate performance in providing accessible, timely, and quality care and services to AHCCCS members. When applicable, HSAG formulated and presented its recommendations to improve Contractor performance rates.

The following sections describe HSAG's findings, conclusions, and recommendations for each Contractor as well as statewide comparative results across the Contractors.

Contractor-Specific Results

AHCCCS provided performance data for the CYE 2007 PIPs for nine Acute Care and DES/CMDP Contractors. The nine Contractors are: APIPA, Care1st, HCA, MHP, MCP, PHS, PHP, UFC, and DES/CMDP. The PIP conducted by all Contractors in CYE 2007 was Improving the Completeness of Physician Reporting to the Arizona ASIIS and focused on increasing the number of primary care practitioners (PCPs) who report immunization information to ASIIS in a timely manner. During CYE 2007, the Physician Reporting to ASIIS PIP was in the first remeasurement phase. The measurement period was from October 1, 2006, to September 30, 2007. The reported measure was the number of PCPs reporting immunization information to ASIIS within 30 days of administration.

In addition, two other PIPs were required for specific Contractors that failed to meet AHCCCS's requirements for successful completion of the PIPs during previous reporting periods. These PIPs included Children's Oral Health (third remeasurement, October 1, 2005, through September 30, 2006) for HCA and MHP, and Immunization Completion Rates by 24 Months of Age (second remeasurement, October 1, 2004, through September 30, 2005) for HCA and PHP.

Arizona Physicians IPA

APIPA serves eligible, enrolled members in all GSAs except for GSA 8 (Pinal and Gila counties) and has contracted with AHCCCS since 1982. At the time of this annual review, the Contractor had approximately 270,930 members.

Findings

Table 8-1 presents the previous baseline and the first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-1—Performance Improvement Projects—Physician Reporting to ASIIS *for* APIPA

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	74.7%	86.4%	15.7%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-1 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. APIPA's reported rate increased from 74.7 percent during the baseline measurement period to 86.4 percent during the first remeasurement period. This increase represents a relative change of 15.7 percent.

As part of its PIP processes, the Contractor implemented several quality improvement interventions derived from having conducted a barrier/causal analyses. In general, APIPA continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications, and included the following quality improvement activities:

- Initiation of mailings, faxes, phone calls, and physician office visits to increase awareness of and compliance with the ASIIS reporting requirements
- Documentation and submission of immunization information to ASIIS when a provider had not reported data within four months
- Implementation of a quarterly interrater review study to evaluate the accuracy of data being supplied to ASIIS
- Participation in meetings with ASIIS to discuss alternative methods for effective and accurate submission of immunization data

Strengths

The Contractor performance results indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days. As such, the results provide evidence of

the combined strength of the Contractor's interventions, showing this PIP activity to be a strength for APIPA.

Opportunities for Improvement and Recommendations

Given the positive outcome presented for the remeasurement year, it is recommended that APIPA continue and/or even further strengthen its current interventions to ensure sustained improvement in its rate.

Summary

The large and significant gain (11.7 percentage points) for the Physician Reporting to ASIIS PIP is a recognized achievement for APIPA. With continued and/or further enhanced improvement activities, it is anticipated that APIPA's improvement in the rates will be sustained or even increased for the second remeasurement period.

Care1st Health Plan

Care1st serves eligible enrolled members in GSA 12 (Maricopa County), and has contracted with AHCCCS since 2003. At the time of this annual review, the Contractor had approximately 27,900 members.

Findings

Table 8-2 presents the previous and first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-2—Performance Improvement Projects—Physician Reporting to ASIIS *for* Care1st

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	76.7%	88.4%	15.2%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-2 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. Care1st's reported rate increased from 76.7 percent during the baseline measurement period to 88.4 percent during the first remeasurement period. This increase represents a relative change of 15.2 percent.

As part of the PIP process, the Contractor operationalized several quality improvement interventions derived from having conducted a barrier/causal analyses. In general, Care1st continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications, and included the following quality improvement activities:

- Modification of operational structures to include a staff position for which the primary responsibility was coordinating EPSDT/ASIIS outreach efforts
- Initiation of mailings, faxes, phone calls, and physician office visits to increase awareness of and compliance with the ASIIS reporting requirements
- Implementation of a comprehensive monitoring program that tracked physician office compliance with reporting requirements, and followed up, by phone or on-site visits, with offices found to be non compliant
- Enhancement of ongoing provider education, including hosting luncheon meetings with physicians

Strengths

The Contractor's remeasurement results indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing this PIP activity to be a strength for Care1st.

Opportunities for Improvement and Recommendations

Given the positive results for the remeasurement, it is recommended that Care1st continue and/or further enhance its current interventions to ensure sustained or even further improved performance rates.

Summary

The large and significant gain (11.7 percentage points) in the rate for the Physician Reporting to ASIIS PIP is a recognized achievement for Care1st. With continued and/or enhanced interventions, the Contractor is anticipated to sustain or further improve its rates for this PIP.

Health Choice Arizona

HCA serves eligible enrolled members in GSAs 4, 8, 10, 12, which include the following counties: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, and Pinal. The Contractor has contracted with AHCCCS since 1990 and had approximately 110,350 members at the time of this annual review.

Findings

In addition to the CYE 2007 AHCCCS-mandated Physician Reporting to ASIIS PIP, HCA was also required to continue two additional PIPs (i.e., Children's Oral Health and Immunization Completion Rates by 24 Months of Age) as a result of not completing them successfully during the previous reporting period. Table 8-3 presents the current and previous measurement results for each of the evaluated CYE 2007 PIPs, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-3—Performance Improvement Projects *for* HCA

PIP Measure	Baseline Measurement Period	First Remeasure-ment Period	Second Remeasure-ment Period	Third Remeasure-ment Period	Relative Percent Change	Statistical Significance (p-value)
Physician Reporting to ASIIS[A]	75.2%	86.5%	N/A[D]	N/A[D]	15.0%	p<.001
Children's Oral Health[B]	49.8%	61.7%	57.6%	58.4%	1.5%	p=.173
Immunization Completion Rates[C]	66.3%	50.3%	62.7%	N/A[D]	24.7%	p<.001

[A] Baseline Measurement Period=October 1, 2004–September 30, 2005; First Remeasurement Period=October 1, 2006-September 30, 2007

[B] Baseline Measurement Period=October 1, 2001–September 30, 2002; First Remeasurement Period=October 1, 2003-September 30, 2004; Second Remeasurement Period=October 1,2004-September 30, 2005; Third Remeasurement Period=October 1, 2005-September 30, 2006

[C] Baseline Measurement Period=October 1, 2002–September 30, 2003; First Remeasurement Period=October 1, 2003-September 30, 2004; Second Remeasurement Period=October 1,2004-September 30, 2005

[D] N/A indicates remeasurement periods not yet completed.

Table 8-3 shows a statistically significant increase (p<.001) in the reported rates for the Physician Reporting to ASIIS and Completeness of Immunization PIPs. The percentage of physicians reporting immunization information to ASIIS within 30 days of administration increased from 75.2 percent to 86.5 percent in the current measurement period and represented a relative change of 15.0 percent. Similarly, the number of completed immunizations for children 24 months of age increased 24.7 percent between measurement periods (from 50.3 percent to 62.7 percent). The second remeasurement period results moved HCA's performance closer to its baseline measurement level. In addition, while HCA's annual dental visit rate from the Children's Oral Health PIP was suggestive of improvement, the change in rates from 57.6 percent to 58.4 percent during the current measurement period was not sufficiently large to reach statistical significance (p=.173). This

finding suggests that the decrease in performance noted in earlier reviews has not yet been sufficiently addressed.

Through the PIP process, HCA operationalized several quality improvement interventions derived from a causal/barrier analyses. As part of its improvement activities to increase physician reporting to ASIIS, HCA continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications, and included the following quality improvement activities:

- Modification of operational structures to include a staff position for which the primary responsibility involved coordinating EPSDT/ASIIS outreach efforts
- Initiation of mailings, faxes, phone calls, and physician office visits to increase awareness of and compliance with the ASIIS reporting requirements
- Augmentation of ongoing provider education focused on increasing awareness of minimum reporting requirements, and targeting of specific physicians
- Provider participation in ASIIS-related meetings

As part of its improvement activities to increase the number of children 3 to 21 years of age who received an annual dental visit, HCA implemented the following interventions to overcome identified barriers to care:

- Produced member handbooks, quarterly newsletters, and mailings in easily understood language that met cultural requirements and promoted the importance of preventive dental services
- Initiated reminders and notifications to both members and providers
- Created an organization-wide culture that adopted the importance of oral health preventive services in daily interactions with members, with other health care providers, and with the general public through health fairs and other community activities

Finally, as part of its improvement activities to increase the number of children whose immunization status is complete by 24 months of age, HCA implemented the following interventions to overcome identified barriers to care:

- Hired an EPSDT outreach coordinator responsible for coordinating all outreach efforts
- Developed a gift certificate incentive for members whose children completed their immunizations by 24 months of age
- Produced member handbooks, newsletters, and mailings promoting the importance of immunizations
- Enhanced current reporting and monitoring activities to include monthly data sheets on the immunization status of children 15 months of age, alert codes to prompt reminders for children 24 months of age, and an internal audit of the immunization records of children who were 24 months of age
- Initiated reminders and notifications to both members and providers
- Created an organization-wide culture that adopted the importance of immunizations in daily interactions with members, with other health care providers, and with the general public through health fairs and other community activities

Strengths

The Contractor results indicated large, statistically significant improvements in the Physician Reporting to ASIIS PIP. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing the Contractor's performance for this PIP to be a strength for HCA.

Opportunities for Improvement and Recommendations

Given the positive outcomes presented for the current reporting cycle for the Physician Reporting to ASIIS and Immunization Completion Rates PIPs, it is recommended that HCA continue and/or further strengthen its current interventions. For the Children's Oral Health PIP, however, the findings suggest that a root-cause analysis should be performed by HCA. Based on the factors and barriers identified during this review, the Contractor should implement additional interventions that address member access to and timeliness of dental visits.

Summary

Rates from the Physician Reporting to ASIIS and Immunization Completion Rates PIPs increased by relatively large, statistically significant amounts during the current measurement period. As such, the findings support the general success of these PIPs and suggest that continued efforts will further increase the rates associated with them. However, the reported rate from the Children's Oral Health PIP did not significantly increase. Moreover, the results from the current remeasurement period suggest that the Contractor's interventions implemented to address the decline in the rate experienced during the previous measurement period for the Children's Oral Health PIP may not have been sufficiently effective to produce and sustain statistically significant improvement.

Maricopa Health Plan

MHP serves eligible, enrolled members in GSA 12 (Maricopa County) and has contracted with AHCCCS since October 1, 1982. At the time of this annual review, the Contractor had approximately 33,800 members.

Findings

In addition to the CYE 2007 mandated Physician Reporting to ASIIS PIP, MHP was also required to continue an additional PIP (i.e., Children's Oral Health) as a result of not successfully completing it during the previous reporting cycle. Table 8-4 presents the previous and current measurement results for each of the evaluated CYE 2007 PIPs, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-4—Performance Improvement Projects *for* MHP

PIP Measure	Baseline Measurement Period	First Remeasure-ment Period	Second Remeasure-ment Period	Third Remeasure-ment Period	Relative Percent Change	Statistical Significance (p-value)
Physician Reporting to ASIIS[A]	77.0%	91.2%	N/A[C]	N/A[C]	18.4%	p<.001
Children's Oral Health[B]	48.9%	41.0%	58.8%	57.9%	-1.6%	p=.350

[A] Baseline Measurement Period=October 1, 2004–September 30, 2005; First Remeasurement Period=October 1, 2006-September 30, 2007

[B] Baseline Measurement Period=October 1, 2001–September 30, 2002; First Remeasurement Period=October 1, 2003-September 30, 2004; Second Remeasurement Period=October 1,2004-September 30, 2005; Third Remeasurement Period=October 1, 2005-September 30, 2006

[C] N/A indicates remeasurement periods not yet completed.

Table 8-4 shows a statistically significant increase (p<.001) in the reported rate for the Physician Reporting to ASIIS PIP. The percentage of physicians reporting immunization information to ASIIS within 30 days of administration increased from 77.0 percent to 91.2 percent in the current measurement period and represented a relative change of 18.4 percent. Conversely, MHP's annual dental visit rate from the Children's Oral Health PIP was statistically unchanged during the current measurement period (p=.350). Although MHP did exhibit a statistically significant increase between the first and second remeasurement period (41.0 percent and 58.8 percent, respectively), the current rate dropped slightly from the second measurement period, from 58.8 percent to 57.9 percent, this change was substantively small, representing a relative change of only 1.5 percent.

Through the PIP process, MHP operationalized several quality improvement interventions derived from a causal/barrier analysis. As part of its improvement activities to increase physician reporting to ASIIS, MHP continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions included the following quality improvement activities:

- Conducting a causal/barrier analysis to survey the reasons for incomplete submissions, which identified the following factors: lack of provider knowledge about ASIIS, information system problems, and inaccurate submissions
- Implementing interventions that targeted noncompliant physicians with letters, phone calls, and office visits, depending on the degree of noncompliance
- Submitting immunization data to the registry when missing data or noncompliant physicians were identified

As part of its improvement activities to increase the number of children 3 to 21 years of age who received an annual dental visit, MHP implemented the following interventions to overcome identified barriers to care:

- Produced member handbooks, quarterly newsletters, and mailings in easily understood language that met cultural requirements and promoted the importance of preventive dental services
- Initiated reminders and notifications to both members and providers
- Created an organization-wide culture that adopted the importance of oral health preventive services in daily interactions with members, with other health care providers, and with the general public through health fairs and other community activities

Strengths

The Contractor's performance results indicated a large, statistically significant improvement in the Physician Reporting to ASIIS rate. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing this PIP to be a strength for MHP

Opportunities for Improvement and Recommendations

Given the positive outcomes for the current reporting period for the Physician Reporting to ASIIS PIP, it is recommended that MHP continue and/or further enhance its current interventions to ensure that its improvement is sustained or even further improved. Additionally, while the Children's Oral Health PIP rate showed sustained improvement during the current measurement period (i.e., a nonsignificant decline in performance), the Contractor should consider evaluating additional factors and barriers affecting children's access to and/or timeliness of dental services.

Summary

Rates for the Physician Reporting to ASIIS PIP increased by statistically significant amounts during the current measurement period. As such, the findings support the general success of this PIP and suggest that continued efforts will result in sustained or further increases in the reported rates. The Annual Dental Visit rate from the Children's Oral Health PIP remained statistically flat. However, the substantively small and statistically nonsignificant decline noted in the Children's Oral Health PIP should not detract from the general success of the PIP in improving the rates during the first remeasurement period and sustaining that improvement through another measurement cycle. Based on the current results, MHP's Children's Oral Health PIP was completed in CYE 2007.

Mercy Care Plan

MCP serves eligible, enrolled members in GSA 2 (La Paz and Yuma counties), GSA 6 (Yavapai County), GSA 10 (Pima County), GSA 12 (Maricopa County), GSA 14 (Graham and Greenlee counties), and limited ZIP Codes in GSA 4 (Coconino County—86336 and 83640) and GSA 8 (Pinal County—85220 and 85242). The Contractor has contracted with AHCCCS since 1983 and had approximately 250,200 acute care members at the time of this annual review.

Findings

Table 8-5 presents the previous and first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-5—Performance Improvement Projects—Physician Reporting to ASIIS *for* MCP

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	74.2%	85.3%	15.0%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-5 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. MCP's currently reported rate increased from 74.2 percent during the baseline measurement period to 85.3 percent during the first remeasurement period. This increase represents a relative change of 15.0 percent.

As part of the PIP process, the Contractor operationalized several quality improvement interventions derived from causal/barrier analyses. In general, MCP continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications and included the following quality improvement activities:

- Initiated direct contact with noncompliant providers (i.e., those who were more than 30 days overdue for reporting) by MCP's EPSDT coordinator to raise general awareness and educate the provider's office administrator on ASIIS requirements
- Enhanced its ongoing provider education by encouraging providers to use their billing systems to automatically load immunization data into the ASIIS database

Strengths

The Contractor's results for this reporting period indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days of administration. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing this PIP activity to be a strength for MCP.

Opportunities for Improvement and Recommendations

Given the positive results for the remeasurement period, it is recommended that MCP continue and/or even further enhance its current interventions to ensure that the improvements in the rates are sustained or further increased.

Summary

The large and significant gain (11.1 percentage points) for the Physician Reporting to ASIIS PIP is a recognized achievement for MCP. With continued and/or enhanced improvement activities, it is anticipated that the improvement in the rates will be sustained or increased during the second remeasurement period.

Pima Health System

PHS serves eligible members in GSA 10 (Pima and Santa Cruz counties) and has contracted with AHCCCS since October 1, 1983. At the time of this review, the Contractor had approximately 27,175 Acute Care members.

Findings

Table 8-6 presents the previous and first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-6—Performance Improvement Projects – Physician Reporting to ASIIS *for* PHS

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	63.9%	85.7%	34.2%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-6 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. PHS's reported rate increased from 63.9 percent during the baseline measurement period to 85.7 percent during the first remeasurement period. This increase represents a relative change of 34.2 percent.

As part of the PIP process, the Contractor operationalized several quality improvement interventions derived from causal/barrier analyses. In general, PHS continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications and included the following quality improvement activities:

- Continued educational outreach for providers on the importance of entering immunization data into ASIIS
- Conducted follow-up calls and visits to noncompliant provider offices
- Conducted a provider survey to evaluate discrepancies between confirmed and audited ASIIS submissions and the lack of completed immunization records in the ASIIS database

Strengths

The Contractor's PIP performance results indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days of administration. As such, the results provide evidence of the combined strength of PHS's interventions, showing this PIP activity to be a strength for the Contractor.

Opportunities for Improvement and Recommendations

Given the positive remeasurement results, it is recommended that PHS continue and/or even further strengthen its current interventions to ensure that the improved results are sustained or improved for the second remeasurement period.

Summary

The large and significant gain (21.8 percentage points) for the Physician Reporting to ASIIS PIP is a recognized achievement for PHS. With continued or further strengthened improvement activities, it is anticipated that the Contractor's improved rates will be sustained or even further improved during the second remeasurement period.

Phoenix Health Plan, LLC

PHP serves eligible, enrolled members in GSA 8 (Gila and Pinal counties) and GSA 12 (Maricopa County) and has contracted with AHCCCS since 1983. At the time of this annual review, the Contractor had approximately 91,000 members.

Findings

In addition to the CYE 2007 mandated Physician Reporting to ASIIS PIP, PHP was required to continue an additional PIP (i.e., Completeness of Immunizations) as a result of not meeting AHCCCS's requirements for successful completion of a PIP during previous reporting periods. Table 8-7 presents the previous and current measurement results for each of the evaluated CYE 2007 PIPs, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-7—Performance Improvement Projects *for* PHP

PIP Measure	Baseline Measurement Period	First Remeasurement Period	Second Remeasurement Period	Third Remeasurement Period	Relative Percent Change	Statistical Significance (p-value)
Physician Reporting to ASIIS[A]	74.0%	86.3%	N/A[C]	N/A[C]	16.6%	p<.001
Immunization Completion Rates[B]	78.3%	82.5%	76.5%	N/A[C]	-7.3%	p=.020

[A] Baseline Measurement Period=October 1, 2004–September 30, 2005; First Remeasurement Period=October 1, 2006-September 30, 2007

[B] Baseline Measurement Period=October 1, 2002–September 30, 2003; First Remeasurement Period=October 1, 2003-September 30, 2004; Second Remeasurement Period=October 1,2004-September 30, 2005

[C] N/A indicates remeasurement periods not yet completed.

Table 8-7 shows a statistically significant increase (p<.001) in the reported rate for the Physician Reporting to ASIIS PIP. Specifically, the percentage of physicians reporting immunization information to ASIIS within 30 days of administration increased from 74.0 percent to 86.3 percent in the current reporting period and represented a relative change of 16.6 percent. Conversely, PHP's rate for the Completeness of Immunizations PIP significantly decreased during the current measurement period (p=.020), dropping 6 percentage points from 82.5 percent to 76.5 percent.

Through the PIP process, PHP operationalized several quality improvement interventions derived from causal/barrier analyses. As part of its improvement activities to increase physician reporting to ASIIS, PHP continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions included the following quality improvement activities:

- Execution and evaluation of the results of a survey conducted to identify barriers to ASIIS immunization reporting. Findings included general lack of awareness, technical problems, and time constraints.
- Implementation of new monthly reports for identifying noncompliant provider offices.
- Initiation of provider follow-up (e.g., letters and education phone calls) for noncompliant physicians that included a survey to capture reasons for reporting delays.
- Continuation of provider education such as lunch meetings.
- Participation in ASIIS-related meetings.

As part of its improvement activities to increase the number of children whose immunization status is complete by 24 months of age, PHP implemented the following interventions to overcome identified barriers to care:

- Hired a maternal and child health/EPSDT quality manager to coordinate overall quality improvement efforts
- Offered a marketing incentive to members for well-child visits
- Implemented an automated reminder system for dental visits, well-child visits, and immunizations
- Augmented educational outreach through member handbooks, newsletters, mailings, and brochures that promoted the importance of immunizations
- Initiated reminders and notifications to both members and providers
- Created an organization-wide culture that adopted the importance of oral health preventive services in daily interactions with members, with other health care providers, and with the general public through health fairs and other community activities
- Identified and shared best practices with PHP-contracted providers, including:
  - Conducting provider telephone reminders to assist members in keeping appointments, and follow-up with members who fail to keep their appointments.
  - Extending providers' office hours to include evenings and weekends.
  - Providing well-visit care, including immunizations, during a sick visit and ensuring that the provider can bill for both.
  - Immunizing siblings who accompany family members to appointments.

Strengths

The Contractor's performance results for the PIP demonstrated statistically significant improvement in the Physician Reporting to ASIIS rates. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing this PIP to be a strength for PHP.

Opportunities for Improvement and Recommendations

Given the positive results for the Physician Reporting to ASIIS PIP, it is recommended that PHP continue or even further strengthen its current interventions to ensure that the improvement in rates is sustained or improved during the second remeasurement period. For the Completeness of Immunizations PIP, however, the findings highlight a clear opportunity for improvement as

evidenced by the substantive and statistically significant decline in rates. As such, it is recommended that PHP conduct a root-cause analysis to identify the factors that account for the decline in rates. Based on the factors and barriers identified during this review, the Contractor should implement additional interventions that address member access to and timeliness of immunizations. These augmented interventions will be important to reverse the decline and ensure improvement in the rates for this PIP.

Summary

PHP returned mixed results for its two PIPs. While the rate for the Physicians Reporting to ASIIS PIP significantly improved between the two most recent reporting periods, the rate for the Completeness of Immunizations PIP significantly declined by 6.0 percentage points.

University Family Care

UFC serves eligible, enrolled members in GSA 10 (Pima County) and has contracted with AHCCCS since October 1, 1997. At the time of this annual review, the Contractor had approximately 8,200 members.

Findings

Table 8-8 presents the previous baseline and the current first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-8—Performance Improvement Projects—Physician Reporting to ASIIS *for* UFC

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	68.2%	87.4%	28.2%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-8 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. UFC's reported rate increased from 68.2 percent during the baseline measurement period to 87.4 percent during the first remeasurement period. This increase represents a relative change of 28.2 percent.

As part of the PIP process, the Contractor operationalized several quality improvement interventions derived from causal/barrier analyses. In general, UFC continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on improving the Contractor's monitoring of providers and included the following quality improvement activities:

- Implemented an annual audit of EPSDT forms to identify missing information that was not reported to ASIIS. When discrepancies were noted, UFC submitted the missing immunization data to ASIIS and conducted follow-up with the providers.
- Based on medical record audits, enhanced educational outreach to provider offices focused on raising awareness of the importance of entering immunization information into the ASIIS database.

Strengths

The Contractor's results indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days of administration. As such, the results provide evidence of the combined strength of the Contractor's interventions, showing this PIP activity to be a strength for UFC.

Opportunities for Improvement and Recommendations

Given the positive PIP results for the first remeasurement period, it is recommended that UFC continue and/or further strengthen its current interventions to ensure that the improvement in the rates is sustained or increased during the second remeasurement period.

Summary

The large and significant gain (19.2 percentage points) for the Physician Reporting to ASIIS PIP is a recognized achievement for UFC. HSAG anticipates that with continued and/or enhanced improvement activities, the gains will be sustained or increased even further during the second remeasurement reporting period.

Arizona Department of Economic Security/Comprehensive Medical and Dental Program

DES/CMDP serves eligible, enrolled members in all GSAs and has contracted with AHCCCS since 2003. At the time of this review, the Contractor had approximately 9,400 members.

Findings

Table 8-9 presents the previous and first remeasurement results for the Physician Reporting to ASIIS PIP, the relative percent change, and the results of statistical testing for the changes in the reported rates.

Table 8-9—Performance Improvement Projects—Physician Reporting to ASIIS *for* DES/CMDP

PIP Measure	Baseline Period[A]	First Remeasurement Period[B]	Relative Percent Change	Statistical Significance (*p* value)
Physician Reporting to ASIIS	73.3%	83.7%	14.1%	p<.001

[A] The baseline measurement period was from October 1, 2004, to September 30, 2005.

[B] The first remeasurement period was from October 1, 2006, to September 30, 2007.

Table 8-9 shows a statistically significant increase (p<.001) in the percentage of physicians reporting immunization information to ASIIS within 30 days of administration. DES/CMDP's reported rate increased from 73.3 percent during the baseline measurement period to 83.7 percent during the first remeasurement period. This increase represents a relative change of 14.1 percent.

As part of its PIP improvement activities, the Contractor operationalized several quality improvement interventions derived from causal/barrier analyses. In general, DES/CMDP continued ongoing efforts to educate providers on the importance of entering data into ASIIS. Interventions centered on provider education and notifications and included the following quality improvement activities:

- Conducted on-site provider visits by DES/CMDP's Provider Services Unit staff to educate provider office staff on the proper submissions of immunization data to ASIIS
- Continued educational outreach and training activities
- Enhanced its provider newsletter to include information on the importance of entering accurate immunization information into ASIIS

Strengths

The Contractor's PIP results indicated a large, statistically significant improvement in the percentage of physicians reporting to ASIIS within 30 days of administration. These results provide evidence of the combined strength of the Contractor's interventions, showing this PIP activity to be a strength for DES/CMDP.

Opportunities for Improvement and Recommendations

Given the positive remeasurement results, it is recommended that DES/CMDP continue and/or further strengthen its current interventions to ensure that the improvement in the rates is sustained or even further increased during the second remeasurement period.

Summary

The large and significant gain (10.4 percentage points) in rates for the Physician Reporting to ASIIS PIP is a recognized achievement for DES/CMDP. With continued and/or further enhanced improvement strategies, it is anticipated that DES/CMDP will show sustained or even further increases in its PIP results for the second remeasurement period.

Comparative Results for Acute Care and DES/CMDP Contractors

AHCCCS calculated and reported the Contractors' performance results for the Physician Reporting to ASIIS PIP that it mandated for the Acute Care and DES/CMDP contractors. The methodologies AHCCCS used to calculate the rates for the PIP remained constant over the two-year period, ensuring the comparability of the results.

Findings

Figure 8-1 presents the two-year comparison of the rates for the Physician Reporting to ASIIS PIP. The figure presents the previous and current rates for each of the Acute Care and DES/CMDP Contractors.

Figure 8-1—2-Year Comparison of ASIIS Reporting Rate *for* Acute Care and DES/CMDP Contractors[8-1]

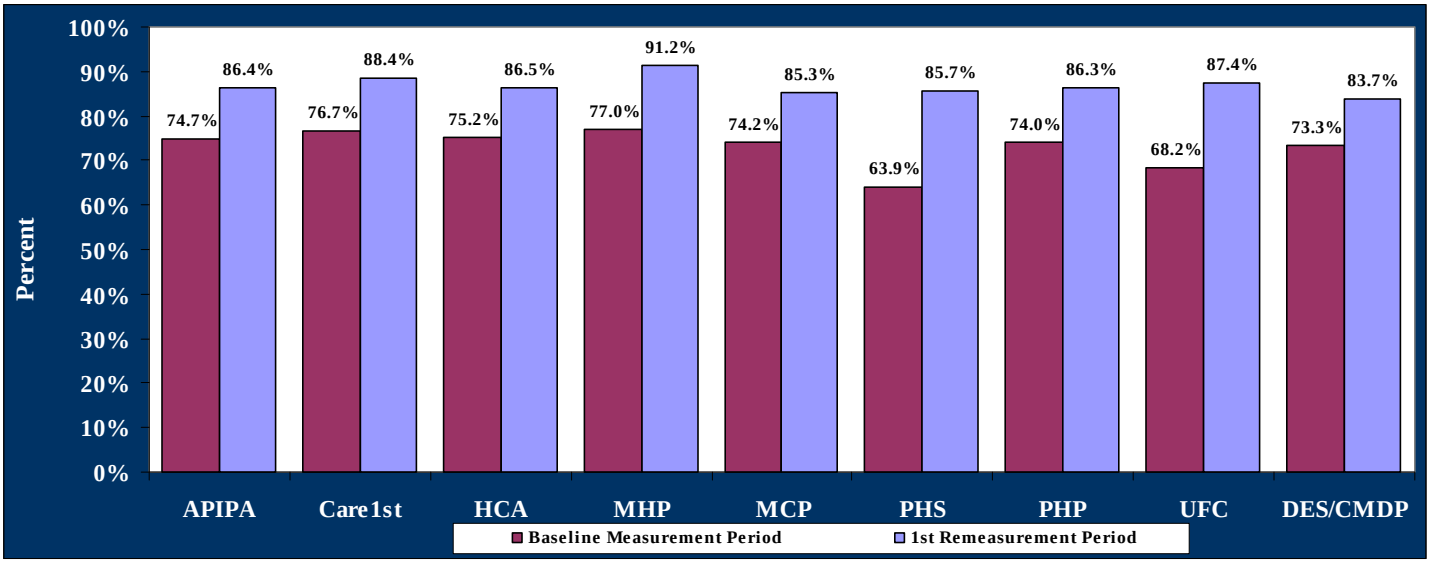


Figure 8-1 shows substantively large and highly statistically significant ($p<.001$) increases for all nine Contractors. The reported rates during the first remeasurement period ranged from 83.7 percent for DES/CMDP to 91.2 percent for MHP. PHS exhibited the largest percentage-point increase (21.8 percentage points) while the smallest increase was exhibited by DES/CMDP (10.4 percentage points). In addition, the lowest rate during the first remeasurement was higher than the highest rate at the baseline. This finding suggests considerable improvement between the baseline and first remeasurement periods and predicts continued Contractor success for this PIP.

[8-1] The Contractors' names are abbreviated as follows: APIPA= Arizona Physicians IPA, Care1st=Care1st Health Plan, HCA=Health Choice Arizona, MHP=Maricopa Health Plan, MCP=Mercy Care Plan, PHS=Pima Health Systems, PHP=Phoenix Health Plan, UFC=University Family Care, and Arizona Department of Economic Security/Community Medical and Dental Program=DES/CMDP.

Strengths

Figure 8-1 demonstrates the relative success of each Acute Care and DES/CMDP Contractor in increasing the percentage of physicians reporting immunization data to ASIIS within 30 days of administration. All nine Contractors increased their rates for this PIP by a statistically significant amount. In addition, the statistically significant increases were substantively large, with all rates increasing at least 10 percentage points. As such, performance on the Physician Reporting to ASIIS PIP is seen as a strength for the Acute Care and DES/CMDP Contractors.

Opportunities for Improvement and Recommendations

Because of the overall excellent Contractor PIP results, HSAG has no recommendations to offer at this time. However, all Contractors should continue or further enhance their improvement activities to ensure that the improvement in their rates is sustained and, ideally, increased even more.

Summary

From baseline to first remeasurement, each of the nine Contractors showed substantive and significant improvements in its rates for the Physician Reporting to ASIIS PIP. With continued and/or enhanced interventions, it is anticipated that, upon a second remeasurement, the Contractors' performance will demonstrate sustained improvement in the rates or even further increases in the rates. AHCCCS and its statewide Contractors are commended for their excellent performance for this PIP.